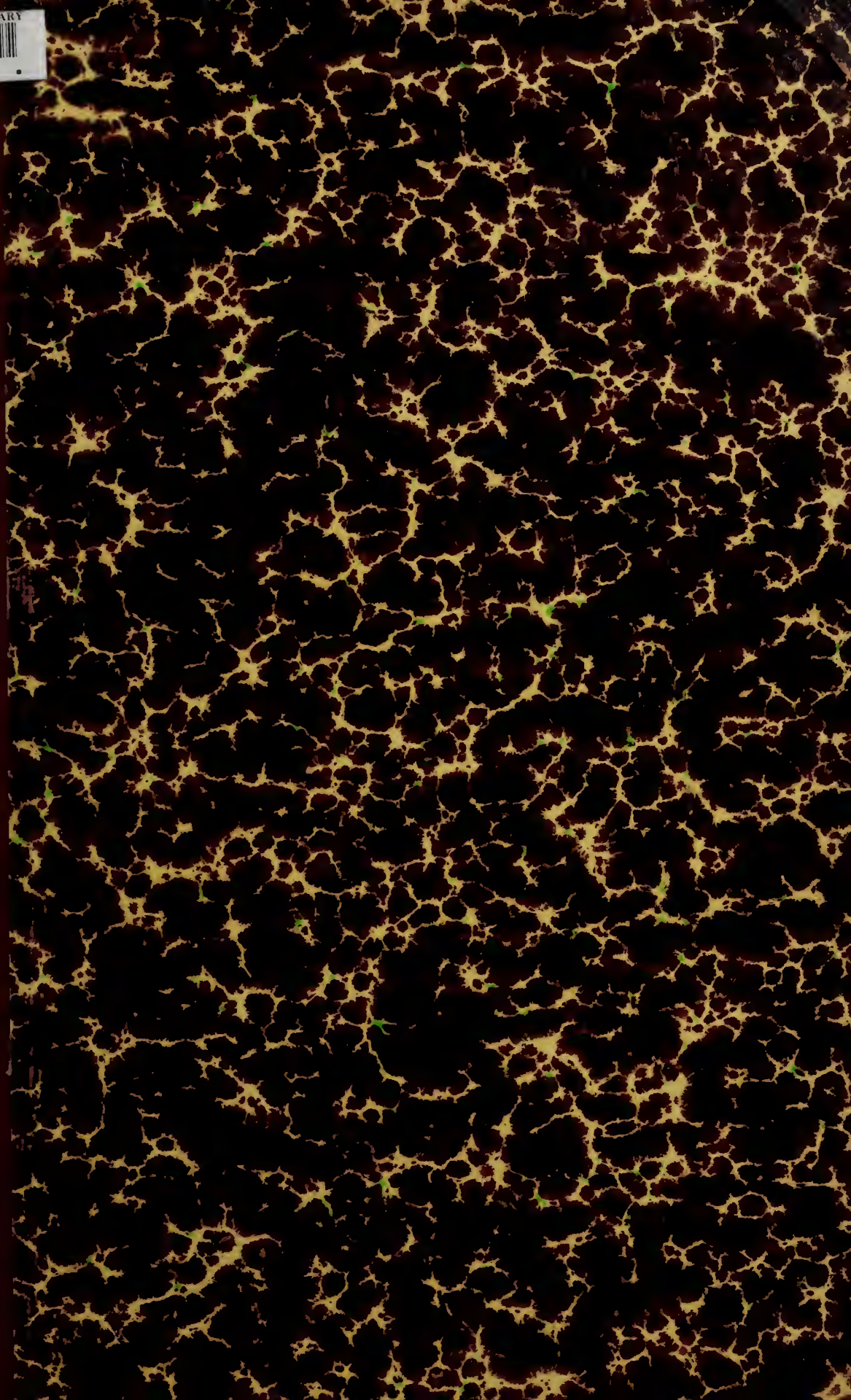


COUNTWAY LIBRARY



HC 3171 .



BOSTON
MEDICAL LIBRARY
8 THE FENWAY

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Owned and Controlled by the Medical Association of Georgia
PUBLISHED MONTHLY under direction of the Council
Copyright, 1945, by the Medical Association of Georgia

Number 1
Volume XXXIV

Atlanta, Georgia, January, 1945

Single Copy, 30 Cents
Per Year - - \$3.00

CONTENTS

Treatment of Cancer of the Breast. J. L. CAMPBELL, M.D., Atlanta.....	1
The Use of the Antistreptolysin Titer in the Differential Diagnosis of Rheumatic Fever and Allied Conditions. HARRY PARKS, Captain M. C., A. U. S., Station Hospital, Fort Benning.....	5
Why Are You A Citizen of Dougherty County? J. M. BARNETT, M.D., Albany.....	10

PRESIDENT'S PAGE

"Twixt Us Doctors." CLEVELAND THOMPSON, M.D., Millen.....	13
--	----

EDITORIALS

Clinical Pulmonary Tuberculosis.....	14
The Year 1945. Will It Be More Blood, Sweat and Tears?.....	15

GEORGIA DEPARTMENT OF PUBLIC HEALTH

The Georgia Rapid Treatment Centers for Venereal Disease. JOHN M. WALTON, M.D., Atlanta.....	16
---	----

(Continued on page VI)

Entered as second class mail at the Post Office at Atlanta, Ga., under the Act of March 3, 1879.
Accepted for mailing at the special rate of postage provided for in Section 1103, Act of Oct. 6, 1917, authorized Nov. 14, 1928.



BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA (Suburb of Atlanta)

FOR NERVOUS AND MENTAL DISORDERS, DRUG AND ALCOHOL ADDICTIONS

ALBERT F. BRAWNER, M.D.
Department for Men

JAMES N. BRAWNER, M.D., Medical Director

JAMES N. BRAWNER, JR., M.D.
Department for Women

Please mention this Journal when writing advertisers

9 out of **10** cases of **EPILEPSY** are treated in the home



THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, January, 1945

Number 1

TREATMENT OF CANCER OF THE BREAST

J. L. CAMPBELL, M.D.
Atlanta

The most important step in the treatment of breast cancer is *early diagnosis*. Not until women realize that a single painless lump in the breast is a danger signal will we be able to make much progress. The educational campaigns being waged by the Women's Field Army and other agencies, together with the conveniently located State-aid cancer clinics, have had some influence in inducing women to apply for aid much earlier than they did twenty-five years ago, but there is still room for improvement.

No less than 50,000 women in the United States have cancer of the breast at the present time. The life expectancy of a woman with an untreated breast cancer is practically three years. This expectancy is not increased when treatment is instituted in the later stages.

There are four conditions or symptoms of the breast for which we are most frequently consulted: a lump, a bloody discharge from the nipple, ulceration of the nipple, and pain.

It is, therefore, our duty to urge every woman who discovers a lump in her breast to consider it an emergency.

The lump is usually discovered by accident and, not being tender nor painful, is apt to be promptly "forgotten." The majority of women think such a lump will disappear in a few days. A spot on the clothing calls attention to the discharge from the nipple and, as a rule, the patient seeks advice promptly; a blood-tinged spot is terrifying. Ulceration of the nipple may

be a simple eczema, a mild dermatitis, or Paget's disease, which is a low grade intra-ductal carcinoma of the upper ducts. Pain is the least dangerous of the four conditions, but the one for which we are most promptly consulted; pain is a reality and something must be done to relieve it.

Excluding pain, which is commonly noticed just before menstruation, a lump is the most frequent complaint and by far the most serious. In women past forty the chances are ninety per cent that it is cancer. Women still delay seeking medical advice because, as they tell us, there was *no* pain. We try to find out how long they have delayed treatment; usually it is from a few days to eighteen months. In the more ignorant group the time is much longer, for poverty and ignorance are twins: work has to be done and the woman has not time to think of herself. Some wait for pain and some for an increase in the size of the lump.

The number of children no longer is believed to influence the development of cancer, for perhaps a few more are seen in single women or married women who have not borne children than in women who have children. A previous abscess, improperly opened, may have some influence in the development of breast cancer. Heredity is being more and more considered, not as a direct cause but as a predisposing factor.

A careful physical examination is important in making the diagnosis. The patient must first be placed in the sitting position; the chest should be bared and the length and size of the breasts carefully noted. Even an early cancer may cause shortening or "squaring" of the affected breast. The slightest dimpling or furrowing of the skin over the lump is significant. Palpation should be made while the patient is still sitting; the gland should be pressed firmly but gently against the chest wall,

beginning at the lower margin and extending upward. Never grasp the breast between the thumb and fingers and pinch it up, as the normal breast tissue may be mistaken for a lump. After the breast has been carefully explored the axilla should be examined, especially the thoracic surface, for the earliest nodes will be felt in the central axillary group.

The examination must not be concluded until all the steps outlined above have been repeated with the patient in the recumbent position; a lump overlooked in the sitting position can sometimes be detected when the patient is lying down.

A discharge from the nipple may be simply a hyperactivity of the cells of the acini or smaller ducts and may result in a galactoceles, should the duct from the secreting area become plugged. This usually occurs after a miscarriage or the premature weaning of the baby. It can be treated medically. If the discharge is serosanguinous or bloody it means, as a rule, papillomatous growths within the ducts. The estimates of the danger of malignancy in this condition varies all the way from five to fifty per cent. The condition should be studied most carefully and, if persistent, it may be treated by irradiation or, if a tumor mass is present, by a simple mastectomy, with a pathologist present to give an opinion as to its malignancy. If malignant, a radical operation should be done.

Pain in the breast is a most distressing symptom. It usually results in a severe cancer phobia which is difficult to allay; but it is rarely the premonitory symptom of malignancy unless a lump is present. So far as the treatment is concerned we must leave that to be considered according to the age and to psychic and other conditions present.

Ulceration of the nipple and areola may be a serious condition and should be given the most careful consideration. It may be a simple dermatitis which, as Bloodgood taught, can be cleared up by thorough washing and a simple ointment. It may be an eczema which will require far more careful attention. However, neither of these conditions should be allowed to persist with-

out satisfying ourselves of their true nature.

A third possibility in ulceration around the nipple is Paget's disease. In addition to the external manifestation it is an intraductal carcinoma of the upper or terminal lacteal ducts. The ulceration has no peculiar characteristics by which its nature can be determined. However, there is generally an area of thickening beneath the areola. Histologically, it is characterized by a peculiar cell known as "Paget's cell." Like other serious conditions of the breast, its true nature should be determined by a biopsy.

Before advising treatment of any disease of the breast a thorough study of the possibilities should be made and the condition classified according to the involvement. An x-ray examination of the chest, back, and long bones should be made, for often the cells of a small tumor may have broken into the blood stream and been widely disseminated.

At the Sheffield Clinic, Atlanta, we try to follow the classification made several years ago by Dr. George E. Pfahler of Philadelphia. He grouped all breast cancers into three classes or stages. To these we have added a fourth stage. In Dr. Pfahler's classification stage or group 1 is a single unattached lump in the breast, freely movable even when the pectoral muscles are fixed by having the patient press the hand firmly against the hip. No palpable nodes in the axilla or above the clavicle. No demonstrable evidence of metastases by x-ray. Stage or group 2: more advanced cases—a lump that has grown rapidly and is sufficiently attached to the skin and fascia to cause distinct striation or dimpling in the skin. Mobility impaired. Palpable nodes in the axilla, but no metastases in the chest or long bones demonstrated by x-ray. Stage or group 3: advanced cases—an infiltrating mass freezing the skin and muscles to the thorax. Demonstrable lymph channels beneath the skin radiating from the primary lesion. Confluent masses of lymph nodes in the axilla or above the clavicle. Retraction of the nipple. Discoloration of the skin over the tumor with metastases to the chest, spine or long bones demonstrable by x-ray examinations.

Stage or group 4 (added by Sheffield Clinic): very advanced cases — ulceration of the skin; breaking down of the deeper structures, the so-called inflammatory cancer. Metastases in the chest, spine, or bones. Enlargement of the liver. Cachexia.

Treatment

Each stage in the course of breast cancer requires a different method of treatment. When the disease has reached the stage where a diagnosis is self-evident treatment is usually only palliative. In the early stage, even after the most painstaking examination, a radical operation should not be made until we are satisfied by a biopsy that the condition is malignant.

There are several methods of making biopsies. Each of these has its advocates; every man believes the method he uses is preferable to all others. Some advocate the punch or aspiration method which to my mind should not be depended on, for although the instrument has entered the tumor it may have missed the malignant area altogether with resulting disaster to the patient. Some feel that no harm will result by removing a section of an unbroken tumor, closing the wound and sending the specimen to the pathologist for an opinion which may require from several days to a week. During this time the tumor cells have the opportunity of entering the lymph or blood vessels to be widely distributed to inaccessible parts of the body.

It seems preferable to have the patient prepared for a radical operation. Then remove the whole tumor if it is not too large or, in case it is, take a good size specimen for frozen section examination. Before even this is done explain to the family what you expect to do if the tumor is malignant and what will be done if it is not. Have at hand a special tray with a few instruments. Prepare the area over the lesion, drape with a few towels; then surround the contemplated incision with gauze wet in alcohol. Make an incision into the tumor and remove whatever size piece you think necessary. There are two checks on this procedure: first, if you are accustomed to the sensation of cutting into a cancer it is nearly as good as your pathologist's opin-



FIGURE 1

Incision A extends from the middle of the clavicle to the border of the latissimus dorsi muscle. The axilla is exposed by reflecting the flap outward to the margin of the deltoid muscle and over the floor of the axilla. Incision B extends from incision A behind the breast to the midline. The lateral surface of the thorax is exposed from the border of the breast to the latissimus dorsi muscle. Incision C extends from incision A over the surface of the breast. Just enough of the flap is lifted to get a good exposure of the axilla. Both muscles are incised at their insertions and reflected inward. The vessels and nerves are exposed and all the branches ligated separately with fine silk. The dissection of the lower and upper flaps is then completed and the breast, with the axillary contents, pectoralis major and minor muscles, is removed from without inward. Care must be taken to protect the long thoracic nerve.

ion: it feels more like cutting into a raw potato than anything I can think of. When you have removed the desired section, control the bleeding and pack the wound with a small piece of gauze wet in ten per cent formaldehyde solution, close the wound tightly, and suture a piece of gauze wet in alcohol over the suture line. Remove all drapery, cleanse the area with alcohol and ether, and prepare the patient for the radical operation as if nothing had been done. Be sure to change gloves and discard the instruments used in making the biopsy; otherwise some cancer cells may be implanted along the line of future incision. By the time you are ready to remove the breast or do a radical operation the pathologist's report will be ready, which checks the impression you had when incising the tumor.

In my earlier experience I used the Halsted incision as modified by Myers. Then I used one described by Jabez Jackson. Lately, or, for the past twelve or fifteen

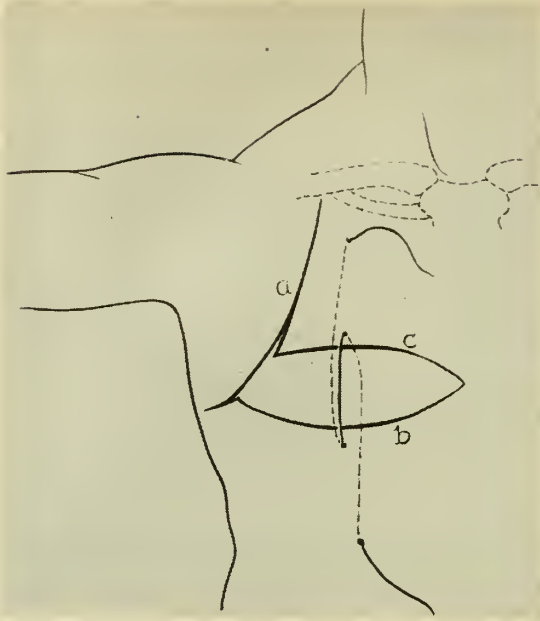


FIGURE 2

The axillary contents, both pectoral muscles and the breast, have been removed. To close the space between B and C with as little tension as possible on the edges, 3 heavy silk sutures are used, the needle is inserted below at the attachment of the flap, passed behind it and through the margin of the upper flap, then through the margin of the lower flap and behind the upper flap to the clavicle, and then drawn moderately tight and tied. The spaces between these sutures, usually about three inches, are closed with fine silk. Finally the edges along incision A are also closed with fine silk. A drain is inserted at the lower end of A, the flaps are pressed firmly against the chest wall with a sea sponge covered with gauze, and held in place by adhesive. The dressing must be changed daily and the sponge pressure kept up for at least ten days.

years, I have been using a modification of the Rodman incision or perhaps it is an incision advocated by Greenough. At any rate, I place the arm at right angle to the body and, when the tumor is located favorably, make a curved incision beginning at the middle of the clavicle and ending at the posterior axillary fold, with the concavity toward the shoulder. The incisions surrounding the breast should also be mapped out, though only by a scratch. The shoulder skin flap is reflected outward until the cephalic vein is exposed, then downward to the posterior axillary fold. Care must be taken not to include any of the deep fascia with the skin flap, for it may contain lymph radicles filled with cancer cells. The pectoral muscles are cut close to their insertions and all the fat and lymph bearing contents of the axilla removed, leaving the brachial plexus, artery and vein clean. The only vessel that will give trouble is the acromial thoracic, as it lies high up and behind the vein.

When the axilla has been cleared the



FIGURE 3

Breast removed 5 years ago. Diagnosis adenocarcinoma. Patient in good condition, free movement of arm, no pain or drawing of the skin over chest.

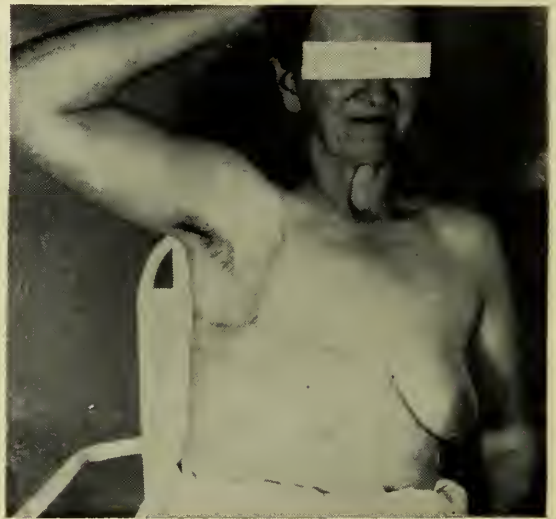


FIGURE 4

Breast removed eight months ago for diffused ductal carcinoma. Free use of arm. Patient lives in the country, has had eight children, is now doing all the work around a North Georgia tenant farmer's home. Too early to predict the outcome, but no sign of any recurrence eight months after operation.

lower breast flap must be dissected well down to the insertion of the rectus muscle and the upper flap raised to expose the clavicular origin of the pectoralis major muscle. At this point I want to caution any one doing a radical breast operation to take great care not to wound the breast tissue, for it may be loaded with cancer cells. After the flaps have been freed it is an easy matter to free the breast, axillary fat and pectoral muscles from the chest wall by working from without inward. The intercostal branches of the internal mammary will give trouble if great care is not taken to control them.

To close the flaps I put in three figure of eight sutures with heavy thread; about

No. 8 spool cotton can be used. The needle is inserted just below the clavicle, comes out from beneath the upper flap, catches the margin of the lower flap, then loops over the margin of the upper flap and beneath the lower flap as far as possible. When tied these sutures take all strain off the margins of the wound, so that the danger of a marginal slough is greatly lessened. The skin margins are approximated with fine cotton or silk thread and a Penrose drain is inserted at the most dependent point. In applying the dressing a sea sponge is used to press the flap well into the axillary space. If this is carefully applied and held down with a broad strip of adhesive there is very little danger from accumulating fluid. I usually remove the drain after forty-eight to seventy-two hours, but keep the sponge in place for a week, changing it daily to prevent any undue pressure.

If no metastases are found by the pathologist when the axillary contents are examined, postoperative x-ray is unnecessary. In cases of moderate malignancy; that is, cells of grade 1 or 2 or even 3, you can count on about ninety per cent of five-year cures. If, however, metastatic nodes are found I believe the chances of five-year cures are reduced probably by twenty-five per cent, but they may be increased by postoperative x-ray treatments.

We cannot promise very much to patients in stage 2 or 3, possibly not over twenty-five per cent in the former and five to ten per cent in the latter, no matter what we do.

Certain factors influence the prognosis even in any stage of growth. If a woman is pregnant or lactating or has just weaned her baby when the disease is discovered, she has practically no chance of complete recovery, but by careful attention her life may be prolonged. If the patient is still menstruating, sterilization is believed to be of some benefit. Again, age is a marked factor: the younger the patient the less her chances of recovery. If she is fat, it is very much against her. All women with breast cancer should be encouraged to reduce and remain just below the normal weight for their age and height.

I will now report briefly the results of

354 cases of breast cancer seen in the Sheffield Clinic. Fifty of these patients were too far advanced to admit for treatment; 149 have died within the last ten years; the remaining 155 were well when last heard from during the past year.

THE USE OF THE ANTISTREPTOLYSIN TITER IN THE DIFFERENTIAL DIAGNOSIS OF RHEUMATIC FEVER AND ALLIED CONDITIONS

HARRY PARKS, Captain M.C., A. U. S.
*Station Hospital,
Fort Benning*

During the winter of 1942 and 1943 a number of patients with symptoms suggestive of rheumatic fever were observed on the medical service of the Station Hospital, Fort Benning, Georgia. The differential diagnosis between rheumatic fever, meningococcic septicemia, and arthralgias of uncertain causes was a difficult problem. Consequently it was decided to study the antistreptolysin titer in addition to other routine laboratory procedures. The purpose of the present communication is to report on the value of the antistreptolysin titer as a diagnostic aid. A by-product of this study is the information obtained as to the relationship of rheumatic fever and preceding streptococcal infection in the South.

There is general agreement that there is more than a coincidental association of streptococcal infection and rheumatic fever. Glover¹ in World War I observed epidemics of rheumatic fever on wards of military hospitals following or coincidental with streptococcal infections; and since this time Paul,² Coburn and Pauli,³ Mote and Jones,⁴ and Wilson,⁵ have abundantly shown that a definite relationship exists between the seasonal incidence of streptococcal infections of the respiratory tract and rheumatic fever. More recently epidemics of rheumatic fever have been reported as taking place in Army camps and Naval training stations during 1942.^{6,7} Todd,⁸ in England, in 1932, described antihemolysin titers in hemolytic streptococcal infection as a specific immu-

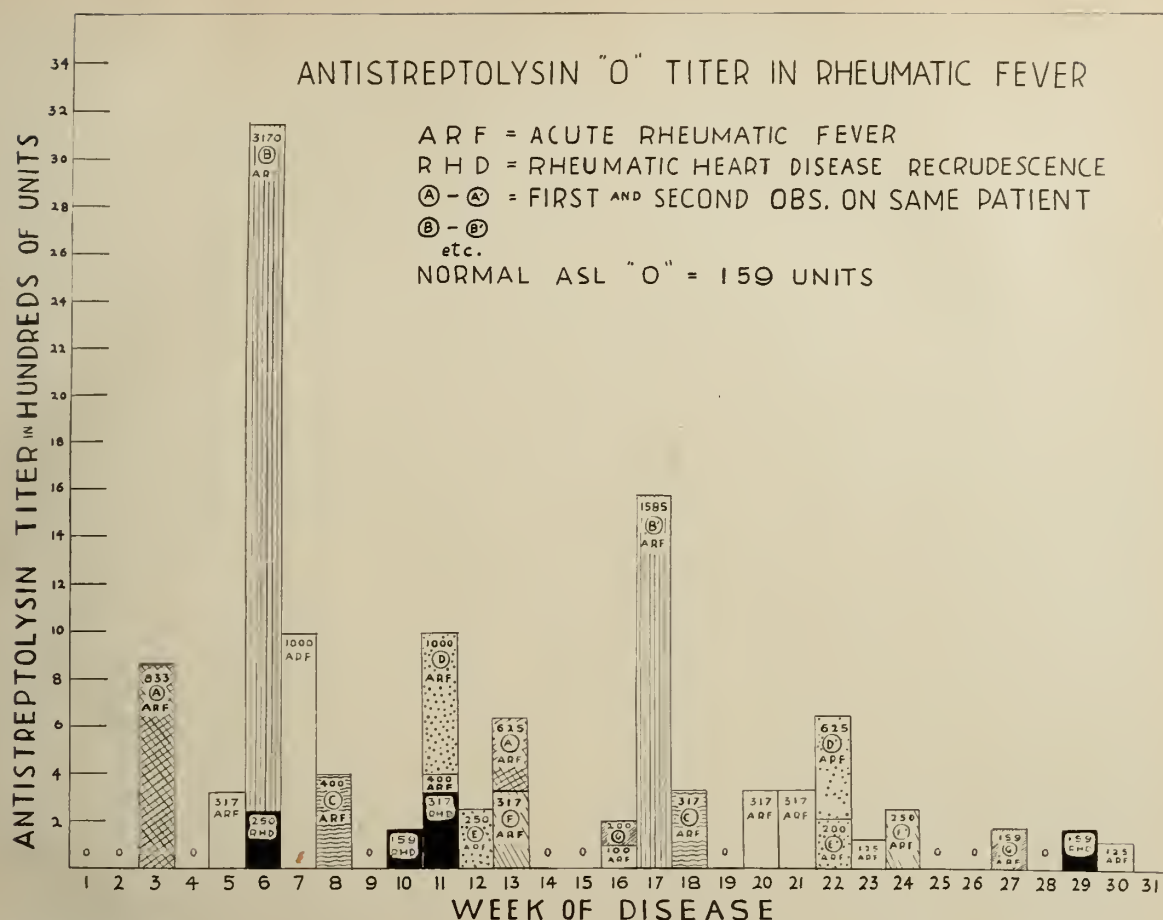
nologic response, and showed that a significant rise takes place in rheumatic fever, erysipelas, tonsillitis and hemolytic streptococcal pneumonia. This study initiated a good many researches on the hemolytic streptococcus which proved that the specific immunologic reaction takes places from one to three weeks after the invasion of human tissues by this organism and its products. Three types of streptococcal products have been found in the serum and are known as antistreptolysins, antifibrinolysins and precipitins; and quantitative measurement of the first, and qualitative measurements of the latter two of these have been made. An exhaustive analytic study of antistreptolysin titers in 2,769 patients reported in 1941 by Mote and Jones⁴ is an interesting contribution to this subject. In this study a group of 749 rheumatic fever patients were observed by these investigators. It was found that after beta hemolytic streptococcal infection — regardless of the type or grouping — there is produced in the serum an agent which combines with and neutralizes the hemolysin produced by the streptococci. This agent is an antigen produced by the organism. Thus it is an antigen-antibody reaction.

The method for determining the antistreptolysin titer is a titration procedure, and the results are expressed in units, 159 units being taken as the upper limit of normal, and 200 units as definite evidence of antistreptolysin response.⁹ Whenever a hemolytic streptococcal infection develops — regardless if scarlet fever, acute tonsillitis, erysipelas, pharyngitis, pneumonia, or acute hemorrhagic nephritis — a rise in titer frequently takes place and lasts several weeks or months and gradually returns to normal. If recurrence or an exacerbation occurs the titer may rise again after it has once fallen. Studies made indicate that there is no relationship of the height of the titer or persistence to the severity of the infection, clinical manifestations, or number of recurrences. Furthermore, a rise in titer may occur without demonstrable evidence of streptococci being present; for example, in the throat or by blood culture. Two types of streptoly-

sins have been described by Todd:^{10, 11} streptolysin O, and streptolysin S. Serologic studies by Todd, Coburn, and Hill,¹² showed that the antistreptolysin S titers of rheumatic children decreased during acute attacks and increased during recovery, whereas the antistreptolysin O increased during the acute phase of rheumatic fever.

Rheumatic fever in the majority of instances behaves in just this manner immunologically. It is for this reason, as has been emphasized by a host of workers in rheumatic fever, that a specific relationship between antecedent beta hemolytic streptococcal infection and rheumatic fever exists. In inactive rheumatic heart disease the titer is usually normal, and with reactivation or recurrence, a rise in titer may occur in a significant number. Patients studied by Bunim¹³ with erythema nodosum of hemolytic streptococcal origin or rheumatic pericarditis were found to have an abnormal titer. When either of these conditions were of tuberculous origin the titer was within normal limits. In rheumatoid arthritis an elevation of antistreptolysin titer did not occur with either the frequency or degree of rise seen in active rheumatic fever. Thus, the use of this procedure in the differential diagnosis of non-streptococcal infections with a bizarre clinical picture may be of value. It should be pointed out that there is disagreement in regard to the prognostic value in this test, but it is agreed that the test is not of specific diagnostic value. Of importance, as pointed out by Bunim,¹³ is to remember that "an elevated antistreptolysin titer may be found in a patient suffering with a disease not related to, but merely preceded by a hemolytic streptococcal infection. To reason that the elevated titer indicates that the presenting disease is of hemolytic streptococcal origin may lead to an erroneous diagnosis. Nevertheless, in the presence of clinically atypical arthritis, the test is useful in a diagnostic manner to help exclude rheumatic fever, since the titer is so constantly increased in this disease."

Twenty-two cases of rheumatic fever were observed at the Station Hospital, Fort Benning, Georgia, from December 1942 until August 1943. Clinical and laboratory



studies were made. Eighteen of the patients were between the ages 21 and 26; the remaining 4 were 32, 29, 18 and 17½ years of age respectively. There were 16 of the white race, 5 colored and 1 Indian. Their residences prior to induction were distributed as follows: 10 of the South, 6 of the North Atlantic Coast and 6 of the Mid-West. In 15 of the patients no previous history of rheumatic fever could be elicited; there was a past history of previous rheumatic fever in 7, as evidenced by an old mitral valvulitis in 6 patients, and a combined aortic and mitral lesion in 1. No two were from the same barracks or hut. They were admitted from three different sections of the reservation, approximately within a radius of fifteen miles; 14 from area A, and 4 from area B and C.

The initial complaints were joint pain, fever, and malaise. Trauma was apparently not associated in any case. Symptoms were followed by the extraction of teeth in 1 case. Practically all were preceded by or associated with a sore throat. The inter-

val between the respiratory infection and onset of joint pain varied from two days to four weeks; and in a few cases the patient had been hospitalized and discharged with a diagnosis of nasopharyngitis, or acute tonsillitis from which they had recovered two to three weeks prior to readmission, and during which time they had been symptom-free. The polyarthritis was not severe, but was incapacitating and involved mainly the knees and ankles with demonstrable swelling, redness and increased heat for the first few days only. Recurrence of mild joint pain occurred in several without any demonstrable findings after complete subsidence of all symptoms. One had joint fluid aspirated from the knee, which on culture was negative. The cardiac symptoms were minimum. Only 3 patients complained of dyspnea, in 2 of whom there was definite obesity and whose weights each were over 200 pounds; 1 patient complained of palpitation; and 2 described a pleuritic type of chest pain. The majority had lost weight prior to admission but a gain in

weight took place during convalescence. Fever of low grade type lasting a few days to several weeks was present in the majority.

Heart murmurs were heard in all but 2 cases. An apical blowing systolic murmur which disappeared after the first twelve days was found in 5; in an equal number there was a basal blowing systolic murmur which was loudest over the pulmonic area, in 1 of which there was an added musical quality; a blowing precordial systolic murmur was heard in 6; and in 2 a typical diastolic murmur of aortic insufficiency was heard, one of which (case 4) developed while under observation, and coincidentally showed the highest antistreptolysin titer of the group. Erythema multiforme was not observed; a lymphangitis above the affected knee, associated with an inguinal adenitis was seen in 1 case. Tachycardia was not present in any of the cases except in the first few days of their disease. No patient developed frank congestive heart failure.

Serial electrocardiograms were normal in 9; abnormal findings were observed in 13 and were classified as follows: prolonged PR interval of 0.22 second or over in 8; ST segment abnormality in 3; bundle branch block in 1; and left axis deviation in 1. Throat culture was positive for hemolytic streptococci in 4 and negative in the remainder. Blood cultures performed in 6 patients were reported negative. Despite the absence of frank urethral discharge in any case, the urine was cultured for gonococci following prostatic massage in each patient and was reported negative in all. The gonococcus complement-fixation test was positive in 7 patients, 3 of whom gave a past history of gonorrhea; but the remainder denied ever having any known venereal infection. These data were not construed to mean that any of the patients had gonorrhea. Agglutinations for undulant fever were negative. The sedimentation rate was normal in 6, and elevated in 16, and required from four to ten weeks to return to normal. The white blood count was normal in 13, mildly elevated in 9, and returned to normal in all. Routine x-ray examination of the chest was normal in 19; but showed a

left lower pneumonitis, cardiac enlargement of the left ventricle, and an old pleural thickening in 1 each of the remainder.

Antistreptolysin titer studies were performed in 19 of the cases, in 7 of which the test was repeated during convalescence. The majority showed an elevated titer above 150 units, indicating the presence of recent or associated hemolytic streptococcal infection.

A total of 26 antistreptolysin titers were performed by T. Duckett Jones, of the Good Samaritan Hospital, Boston, Mass., as arranged by Col. Dwight Kuhns, Commanding Officer of the 4th Service Command Laboratory, Atlanta, Georgia. (see table 1 and figure 1).

TABLE 1
ANTISTREPTOLYSIN "O" IN RHEUMATIC FEVER

<i>Number</i>	<i>Week of Disease</i>	<i>Units of ASL "O"</i>	<i>Diagnosis</i>
1	3	833	Ac. R.F. ACTIVE
	13	625	
2	5	317	Ac. R.F. ACTIVE
3	6	250	R.H.D. RCRD
4	6	3170	Ac. R.F. ACTIVE
	17	1585	
5	7	1000	Ac. R.F. ACTIVE
6	11	400	Ac. R.F. ACTIVE
7	8	400	Ac. R.F. ACTIVE
	18	317	
8	10	159	R.H.D. RCRD
9	11	1000	Ac. R.F. ACTIVE
	22	625	
10	11	317	R.H.D. RCRD
11	12	250	Ac. R.F. ACTIVE
	22	200	
12	13	317	Ac. R.F. ACTIVE
	24	250	
13	16	200	Ac. R.F. ACTIVE
	27	159	
14	16	100	Ac. R.F. ACTIVE
15	20	317	Ac. R.F. ACTIVE
16	21	317	Ac. R.F. ACTIVE
17	23	125	Ac. R.F. ACTIVE
18	29	159	R.H.D. RCRD
19	30	125	Ac. R.F. ACTIVE

Ac. R.F.—Acute Rheumatic Fever
R.H.D.—Rheumatic Heart Disease
RCRD—Recrudescence
ASL—Antistreptolysin
NORMAL TITER—159 Units

The sera were analyzed without knowledge of the clinical diagnosis. Because of the study having begun in April 1943, the majority of the cases of rheumatic fever had titer studies made in various stages of their disease, from the 3rd to 30th week

after onset of symptoms. In 7 instances a second titer was performed showing a fall in titer in all cases as improvement in the clinical condition took place. In addition to acute rheumatic fever first attacks, 4 patients with rheumatic heart disease, with mitral lesions, were considered to have recurrence; in 1 severe and in 1 moderately severe case the titer was elevated; and in 2 the titer was found to be at the upper limits of normal during the 10th and 29th

TABLE 2
SUMMARY OF ANTISTREPTOLYSIN
TITER STUDIES

	<i>Normal</i>	<i>Elevated</i>	<i>Total</i>
Acute Rheumatic Fever.....	*3	12	15
Rechecks	1	6	7
Rheumatic Heart Disease....	3	2	4
	—	—	—
	7	20	26
Rheumatoid Arthritis	4	2	6
With Urethritis, Gonorrheal	1	1	2
With Urethritis, Nonspecific	0	1	1
Arthralgia	8	1	9
Rechecks	1	0	1
	—	—	—
	14	5	19
Hysteria	1	0	1
Meningococcemia	**2	***2	4
Rechecks	2	1	3
Acute Pulmonary Edema Complicating Acute Ne- phritis	1	0	1
Infectious Mononucleosis; and Post-Tonsillectomy Convalescent	****0	1	1
Normal: Usual Colds and Sore Throats	1	0	1
	—	—	—
Contact with Above Ac. R.F. Cases	7	4	11

*ASL Titer Determination made at 16, 23 and 30 weeks respectively.

**Recheck 11 weeks later showed normal values.

***Recheck 11 weeks later showed fall from 625 to 400 units in one case.

****ASY Determination elevated to 400 units, 3 months post-tonsillectomy.

week respectively. An additional 30 antistreptolysin titers were performed in other rheumatic and miscellaneous conditions as controls, which included rheumatoid arthritis, arthralgia, meningococcemia, hysteria, acute pulmonary edema, convalescent tonsillectomy, and infectious mononucleosis.

Of a total of 26 observations (see table 2) in the rheumatic fever group, 20 were elevated; 6 were normal. In the group with rheumatoid arthritis and arthralgias 19 observations were made and 14 were normal, 5 were elevated. In the miscellaneous group 11 observations were made and 8 were normal; 3 were elevated. It is of interest that three occurred in 2 patients with proven meningococcemia, who probably had concomitant hemolytic streptococcal throat infections.

The immunologic effects of hemolytic streptococcal infections in people in various parts of the globe have been studied, but conflicting opinions exist. Morales-Otero and Pomales-Lebron¹⁴ found significantly elevated antistreptolysin titers in the sera of many individuals with a history of previous pharyngitis in Puerto Rico. Plummer¹⁵ compared hemolytic streptococcal antitoxin potency of sera from individuals in Toronto, Canada, with those of tropical areas of Manila, East Africa, South America, Madras and Punjab, and found that the tropical sera showed higher antitoxin potencies than the Canadian sera. Coburn and Pauli¹⁶ have reported that median antistreptolysin titers are lower in the bloods of normal individuals living in latitudes south of 35 degrees than in latitudes north of 40 degrees. Despite the fact that rheumatic fever occurred in the southern part of the United States, the antistreptolysin titers in this study indicate the same associations with hemolytic streptococci as those cases reported from the northern part of the United States.

Conclusions

It is obvious that no definite conclusions can be drawn from such a small group of cases. Nevertheless, there does appear to be a significant difference in the result of antistreptolysin tests between patients who clinically had rheumatic fever and those with other conditions. The majority of active rheumatic fever patients of a group of 19 cases studied showed an elevated antistreptolysin "O" titer of the blood serum. A smaller proportion of cases with other infectious diseases also showed elevated antistreptolysin titers. In any individual case

the test cannot be used to establish or rule out the diagnosis of rheumatic fever, but it is often useful as an adjunct in diagnosis. Antistreptolysin titer responses appear no different in cases of acute rheumatic fever occurring in the southern part of the United States than in those reported in the northern states.

Thanks are due Dr. Paul Beeson of Emory University Medical School, Department of Medicine, for the many helpful suggestions in carrying out this study.

BIBLIOGRAPHY

1. Glover, J. A.: *Milroy Lectures on the Incidence of Rheumatic Diseases*, Lancet, 1: 499-507, 1930.
2. Paul, John R.: *The Epidemiology of Rheumatic Fever and Some of Its Public Health Aspects*. Edition 2, Metropolitan Life Insurance Company, 1943.
3. Coburn, A. F., and Pauli, R. H.: *Studies on the Relationship of Streptococcus Hemolyticus to the Rheumatic Process: I. Observations on the Ecology of Hemolytic Streptococcus in Relation to the Epidemiology of Rheumatic Fever*, J. Exper. Med. 56: 60-676 (Nov.) 1932.
4. Mote, John R., and Jones, T. Duckett: *Studies of Hemolytic Streptococcal Antibodies in Control Groups, Rheumatic Fever, and Rheumatoid Arthritis. I. The Incidence of Antistreptolysin "O", antifibrinolysin and Hemolytic Streptococcal Precipitating-Antibodies in the Sera of Urban Control Groups. II. The Frequency of Antistreptolysin "O", Antifibrinolysin, and Precipitating-Antibody Responses in Scarlet Fever, Hemolytic Streptococcal Infections, and Rheumatic Fever. III. The Magnitude of Antistreptolysin "O", Antifibrinolysin, and Precipitating-Antibody Responses; the Persistence of the Antibodies, and Variations in Antistreptolysin "O" Curves in Scarlet Fever, Hemolytic Streptococcal Infection, and Rheumatic Fever*, J. Immunol. 41: 35-118 (May) 1941.
5. Wilson, M. G.: *Rheumatic Fever*, New York, The Commonwealth Fund, 1940, pp. 78-95.
6. Boisvert, Paul L.; Dawson, M. Henry; Schwenker, Frances F., and Trask, James D.: *Epidemic Rheumatic Fever*, Ann. Int. Med. 19: 107 (July) 1943.
7. Lhamon, R. M.; Huntington, R. H.; Wheeler, Stafford M., and Jones, T. Duckett: *An Epidemic of Hemolytic Streptococcus Infection and Rheumatic Fever Among Naval Trainees*, Ann. Int. Med. 19: 107-111 (July) 1943.
8. Todd, E. W.: *Antihemolysin Titers in Hemolytic Streptococcal Infections and Their Significance in Rheumatic Fever*, Brit. J. Exper. Path. 13: 248-259, 1932.
9. Personal Communication.
10. Todd, E. W.: *Britt. J. Exper. Path.* 19: 367, 1938.
11. Todd, E. W.: *J. Path. & Bact.* 47: 423, 1938.
12. Todd, E. W.; Coburn, A. F., and Hill, A. B.: *Lancet* 2: 1213, 1939.
13. Bunim, J. J. and McEwen C.: *The Antistreptolysin Titer in Rheumatic Fever Arthritis and Other Diseases*, J. Clin. Investigation 19: 75-82 (Jan.) 1940.
14. Pomales-Lebron, A.: *Study of Hemolytic Streptococci as Found in Tropical Island of Puroto Rico, Puerto Rico* J. Pub. Health & Trop. Med. 16: 66, 1940.
15. Plummer, H.: *Studies in Scarlet Fever Immunity*, J. Immunol. 35: 235, 1938.
16. Coburn, A. F., and Pauli, R. H.: *Limited Observation on the Antistreptolysin Titer in Relation to Latitude*, J. Immunol. 29: 515, 1935.

WILLIAM BEAUMONT HONORED

Organization of the Dr. William Beaumont Memorial Foundation is announced in a handsome brochure now available to members of the profession. The home of the foundation is at Prairie Du Chein, Wisconsin, where Dr. Beaumont carried on many of his history-making experiments. It is housed in a restoration of the old Fort Crawford Military Hospital.

The foundation was organized as a memorial to the pioneer physiologist and as an American medical shrine.

It is sponsored by a group of eminent medical men and community-minded Wisconsin citizens.

WHY ARE YOU A CITIZEN OF DOUGHERTY COUNTY?

J. M. BARNETT, M.D.
Albany

Before entering into a discussion of my subject, which in no way identifies the substance of my talk, I think it well that I give you a detailed outline of my activities in relation to malaria control in Dougherty County.

In 1902 my services were secured by the Red Cypress Lumber Company to take charge of a mill village west of Albany, Georgia, known as Preteria. This village was established in 1897 with a population of 3,000, including the surrounding neighborhood and large farms. The laborers were made up of native Negroes and native whites, together with Finns, Poles, Germans and Italians. At that time malaria was very prevalent with a high death rate. By actual test 72 per cent of the population were infected with malarial parasites. Rapid strides were made and no expense spared to rid this vicinity of malaria.

In 1904 progress had been made and much publicity and recognition given to methods of procedure which consisted of a five-point control program; education, ditching, screening, oiling, and the use of drugs. At this time Dr. H. F. Harris, Director of the Georgia State Board of Health, came down and established a branch laboratory, which I think was the first State Branch Laboratory in Georgia. Dr. Harris cooperated fully and gave valuable suggestions in attaining early success in this great venture, the first of its kind in the history of the United States. All the Southern cities throughout the malarial districts of the South were visited to find out just what was being done about preventive measures against malaria. It was ascertained that all malarial control was directed in the treatment with drugs and nothing was being done to destroy the mosquito, or to protect the carrier other than by drugs.

Malaria is one of the oldest diseases with

Delivered before the Rotary Club, Albany, Ga., Nov. 16, 1944. Presented with moving pictures (by invitation).

which man is afflicted, but little had been accomplished until 1880 when Laveran, an Army surgeon in Algeria, discovered the malaria parasite in the blood of man. Then seventeen years later, Sir Ronald Ross, of the Indian Army Service, identified the anopholes mosquito as the vector of this disease. Major Walter Reed who had studied under Welch, of John Hopkins in 1900, was detailed to head a board to study yellow fever in Cuba, then occupied by the U. S. Army. At this time Major Reed had discovered that yellow fever was caused by a filterable virus transmitted to man by a particular mosquito species, the *Aedes Aegypti*. There are 1,000 species of mosquitoes and only twenty of these are known as disease carriers, and there are nine diseases today transmitted by the mosquito.

In 1915 the people of Dougherty County, Georgia, became interested in a malarial control program. In 1916 the Dougherty County Board of Health was established. Thereafter the Ellis Health Law was adopted, Dougherty County being one of the first counties to adopt this document and to inaugurate an intensive malarial control campaign. The major purpose of the board was to rid Dougherty County of malaria.

On a limited budget, work was begun and methods of control were ditching, oiling and screening.

M. A. Barber in 1921 gave us the first report in the use of Paris Green dusting as a larvicide. In 1926 Dr. W. E. Deeks gave us further information on the use of Paris Green dusting on the United Fruit Company's farm in South America. Again Dr. S. T. Darling, a research worker from Rockefeller Institute, was engaged in malarial study in Lee County, Georgia, and was made an honorary member of our board, and encouraged us to give a trial of the Paris Green dusting to control mosquito breeding. In 1928 our health commissioner, Dr. Hugo Robinson, was sent to Washington to consult directly with the U. S. P. H. Service. In 1929 Dr. L. L. Williams from the U. S. P. H. Service was sent to confer with us regarding our needs and perfecting our plans of control.

The cost and needed aid were discussed,

and necessary funds raised. Dr. T. H. D. Griffiths, a specialist in malarial control work, was employed. Dr. Williams in turn made a full report to the Director of the Georgia State Board of Health. The project was launched primarily in the nature of an experiment and a demonstration of Paris Green dusting to control breeding over an area of 343 square miles.

At the close of 1932 time and records showed that we had accomplished one of the greatest civic projects in the history of preventive medicine, an accomplishment which rendered great satisfaction to those actively engaged in this undertaking.

The Dougherty County malarial blood indices in 1929 showed positive infections of 47 per cent of the pupils of the white and Negro schools. In 1932, 13.5 per cent; 1936, 1.11 per cent. In the past eight years not more than two or three cases a year have been reported, and in the past year not a single authentic case has been reported, thus giving you an idea of our graduated gains in malarial control.

Drainage has been accepted as the basic and most effective of all mosquito control methods. In our surveys and activities this has been kept in mind. We have 900 major ponds under larvicide control, consisting of 4000 acres of land in normal seasons. To date there has been constructed 75 miles of drainage ditches. It is estimated that we will need about 100 miles additional drainage ditches, these to be located where drainage is feasible from the standpoint of construction.

Malaria, the great "mimic disease" is coming into its own following the war. Surgeon General Thomas Parran, U. S. P. H. Service, recently told a congressional committee that malarial experts estimate there will be at least 1,000,000 carriers of the disease when the troops come home. The military doctors are fearful that the civilian practitioners who have had little or no experience with the disease will fail to recognize it when it recurs among the returned veterans or when a case of smoldering malaria suddenly comes to the front.

The disease might easily be mistaken by those not familiar in the diagnosis of ma-

laria, for appendicitis, pleurisy, meningitis and a score of other diseases too numerous to mention.

How great are the chances that "Old Doc Jones" will be confronted with these cases that are so misleading? Malaria recurs in about 50 per cent of cases — there is no cure-all. The drugs quinine and atabrine serve mainly to suppress the infection, thus giving the body a chance to mobilize its defenses, which in turn leads to cure in many cases. Spontaneous cures are not uncommon.

The anopheles — or "Bloody Anne" as fighting men dub it — thrives in many sections of this country, but in the colder areas is not so common. Nevertheless, there are dangers of a regional and local outbreaks, and health authorities are already preparing to meet them.

To better prepare the Navy doctors for the treatment of malaria and other tropical diseases a new school of tropical medicine has been established at Treasure Island.

Blood tests will be the procedure which doctors must use in all doubtful cases.

In summarizing the malaria control work in Dougherty County, by our Board of Health for the past twenty-eight years, with the able guidance of the Sanitary Engineering Division of the Georgia Department of Public Health and the U. S. P. H. Service, one observation is unanimous; that is, the end results have justified the expenditure.

Dougherty County bears the distinction of pioneering in this work and having the first scientific program of its kind in the country, made possible through a special one-mill tax and this special tax is common knowledge in the community, and the idea originated with the Health Board and was carried to the taxpayers and approved by them. Adequate health protection is purchasable and Dougherty County, along with its many neighbors, is now more than ready to pay the price, as its citizens realize such expenditures bring valuable returns. There is actual saving of lives and suffering. Outside industries have changed Dougherty County from an economic unfavorable status to an economic favorable

white spot on its map of business attractiveness.

Why do you live in Dougherty County? *Ducit amor patriae*? No, no, it is the betterment of living conditions with the elimination of that scourge and subtle disease, malaria — bringing in new industries, land tripled in value and productivity, giving a brighter future for better, stronger, more healthful people.

"Now that it's all over, what did you really do yesterday that's worth mentioning today?"

HOSPITALS APPROVED FOR GRADUATE TRAINING IN SURGERY

The American College of Surgeons announces that 231 hospitals in the United States and Canada have been approved for Graduate Training in general surgery and the surgical specialties. The list of approved hospitals for this purpose is published in the annual Approval Number of the Bulletin of the College just issued. As a result of the 1944 survey, nine additions to the Approved List was made compared with last year.

In announcing the new Approved List, Dr. Malcolm T. MacEachern, Associate Director, states that 500 or more surveys of hospitals offering opportunities for graduate training in surgery are planned during the coming year, the increased emphasis upon this work being stimulated by the need for providing ample opportunities for resumption of training by medical officers when they return from service with the Armed Forces. The College, through Major General Charles R. Reynolds, Consultant in Graduate Training in Surgery; Dr. George H. Miller, Director of Educational Activities; Dr. Paul S. Ferguson, Director of Surveys, and a field staff, helps hospitals to organize graduate training programs to meet the requirements for approval, and also plans to aid physicians returning from service in resuming their training in surgery.

GEORGIA HOSPITALS APPROVED ARE:

ATLANTA

Grady Hospital—625
General Surgery
Urology
Obstetrics and Gynecology
Ophthalmology and Otolaryngology

AUGUSTA

University Hospital—340
General Surgery
Obstetrics and Gynecology

EMORY UNIVERSITY

Emory University Hospital—231
General Surgery

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

THE PRESIDENT'S PAGE

'TWIXT US DOCTORS

During the past year every doctor in Georgia experienced the heaviest, hardest year's work of his entire career — and this regardless of his age. What is more, there is no possibility of its being any less heavy during the next twelve months, and if there should be any serious epidemics it may be impossible to supply adequate medical attention. The only way I see that we can carry the load, which gets irksome before the long days are over, is to remember enthusiastically the real service we are doing; that while our comrades are on alien ground fighting the "battle for the survival of civilization," we are doing our part here at home. We recall the little parable of three brickmasons who when asked what they were working for: the first replied, "For \$2.00 an hour"; the second, "To get food and clothes for my family"; the third replied enthusiastically, "I am building a beautiful cathedral."

Most of us have all three of the incentives driving us on. It is gratifying that

there is more money for the doctors than usual, with less charity work; that the wife and children can be humored a little more, and that we ourselves can afford a hobby even if we have no time for it. The Lord knows it is time for such a break! But there is a possibility that we may get a big case of "ego" in the process. I have often remarked that preachers and doctors are the vainest men in the catalog: vain because so many of their fellow-beings, coming to them in the extremity of soul or body, exhibit everlastingly, deferential gratitude and love.

What I wish to emphasize is how very much humility and self-forgetfulness it takes to do honest "doctoring," and to administer it with understanding sympathy. More than ever we need more strength and courage to sustain us through the toil and the disappointment and the sorrow and the success and the gladness that lie ahead of us in the coming months.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

JANUARY, 1945

**CLINICAL PULMONARY
TUBERCULOSIS**

The purpose of this article is to outline for the general practitioner a working formula for establishing the diagnosis of clinical pulmonary tuberculosis; or, by the same token, to eliminate it as a diagnostic consideration. It is not a formula to be applied mechanically and with little or no cerebration on the part of the examiner, but rather its success, or lack of it, will depend in large measure upon the thoroughness, experience and astuteness that backdrops its application. As stated, it is an outline that should serve as a helpful guide toward this objective, and which abolishes some of the unnecessary and confusing detours.

The measures required in this formula are a short well-taken history, a physical examination of the chest, sputum studies and x-ray examinations. In most instances these will completely suffice. At times, particularly in differential diagnosis, more specialized procedures as bronchoscopic examination and x-ray visualization following the instillation of iodized oil, are required. A negative reaction to a properly done tuberculin skin test is very strong evidence against tuberculosis being the offending disorder.

The history concerns itself chiefly with a description of the symptoms — their character and duration — and an inquiry into the question of contact, particularly a family one. It has been aptly remarked that in a patient having symptoms of tuberculosis, the diagnosis can be anticipated in most instances from across the consultation desk.

While this discussion deals with clinical tuberculosis — in patients who are suffering from it — before any further elaboration of these symptoms is indulged this poignant interpolation should be emphat-

ically stated. The *diagnosis* of tuberculosis can be and should be made *before* symptoms appear.

Since the familiarity of the profession with the cardinal symptoms is so commonplace, only a few directional high-lights will be here entertained.

A cough of a few days or weeks, particularly following an upper respiratory infection, does not suggest tuberculosis, but one persisting for several weeks or months very pointedly does so. A rather severe barking cough over a period of years with little or no impairment of the general health, suggests a bronchial disorder. This is especially true where there is a seasonal emphasis. The cough in tuberculosis is rarely of the hard-wracking type, and then is confined to the far advanced cavernous cases and in cases of tracheobronchial ulcerative stenosis. The so-called hacking cough quite nicely described the average cough encountered in pulmonary tuberculosis.

A mucoid or muco-purulent sputum is that which is usually raised in tuberculosis. With some frequency it is streaked or stained with blood. Copious foul sputum is rare, and usually indicates a suppurative process in the lung or bronchial tubes. A sputum with any odor is very infrequent, but is occasionally noted in large infected cavities. Excessive secretion in tuberculosis is definitely on the exceptional side, and its presence strongly calls for other diagnostic considerations.

Hemoptysis or frank pulmonary hemorrhage is common in pulmonary tuberculosis, and it is a *must* that its occurrence calls for this disease to have top priority consideration. Expectoration of blood is common in lung abscess, bronchiectasis and bronchiogenic carcinoma. It might be well to forget the blood came from the throat.

The fever curve in tuberculosis with its sub-normal morning recording and an elevation of 99 to 100 in the late afternoon or early evening, is well known. Except in the toxic, far advanced terminal cases and those with certain complication, the fever is rarely high or spiked. One of the characteristics of the fever in this disease — and at times of diagnostic import — is the promptness

with which it responds to a few weeks, or even days, of bed rest.

An unexplained loss of weight and an unexplained fatigue should involve at all times the question of the presence of tuberculosis. Quite often such will be the answer.

Finally, before leaving the discussion of symptoms, it is well to stress the significance of a proved pleurisy. In the vast majority of instances, the tubercle bacillus is the causative agent. This is overwhelmingly true in those cases with effusion.

A thoroughly and meticulously performed physical examination of the chest is of course essential, but it is quite true that today a closer adherence is observed to the slogan, "Tuberculosis should be seen rather than heard." Probably the most important single maneuver is the exploration of the upper half of the chest during inspiration following the expiratory cough. The rules of early infiltrative lesions are best brought forth in this manner. The auscultatory presence or absence of moisture is also of considerable significance. The most signal fact regarding the physical examination is that, even when done with the utmost skill and in the hands of the experienced expert, there may be no abnormal findings even though moderately or far advanced disease is present.

Now comes the most important diagnostic aid of all — the x-ray examination. No examination for pulmonary tuberculosis is complete or even adequate without it. The fluoroscopic examination in very experienced hands is usually a fair substitute and always an excellent adjuvant, but early or minimal disease can be easily missed. The best diagnostic investigation is the conventional 14 x 17 inch film. For mass x-ray surveys, because of economy and speed, the miniature films, employing the principle of photo-fluography, are being widely used today. The x-ray examination may disclose the presence of tuberculosis months before symptoms appear. It is obvious that this is the time to make the diagnosis — a time when the disease is readily curable.

Lastly, in this brief diagnostic parade, is the search for the etiologic agent — the tu-

bercle bacillus. It is to be hoped that the diagnosis will be made before the bacilli appear in the sputum or gastric contents. In addition to the regular slide method, resort can be had to culture and animal inoculation in suspected but unproved cases. Finding the tubercle bacillus in the sputum is almost always conclusive proof of the existence of tuberculosis, but let it be profoundly hoped that more and more in the future this proof will not be required.

It is my sincere wish that the proper integration and application of this diagnostic approach to tuberculosis of the lungs will prove of some aid in the control of this terrible menace to our individual and national health.

CHAMP H. HOLMES, M.D.

THE YEAR 1945. WILL IT BE MORE BLOOD, SWEAT AND TEARS?

The year 1945 has come. Those of us whose wishes for World War II to be over in 1944 have been disappointed. And all of us, whether interested in the culmination of wars or in problems more directly concerned with our daily lives, must admit now that any war changes the trend of all things.

For the medical profession the war years have been most strenuous. Approximately 60,000 physicians of the United States are serving now in some branch of our government, many of them in the armed forces in the various theaters of operations. To all of them THE JOURNAL extends New Year's felicitations, and best wishes for their health and for their work. At the same time all of us who were left at home wish for them a speedy return to their homes, to their families and to their practices.

Those of us who were left at home have been disillusioned if any of us ever thought the American people did not desire more medical care. We have worked all the hours that our minds and bodies would withstand, and it is certain we will continue to work to do everything we can to alleviate suffering humanity and to help in every effort to extend medical, nursing and hospital care, and public health, so that every American can continue to say that he or she

(Continued on page 19)

GEORGIA DEPARTMENT OF PUBLIC HEALTHT. F. ABERCROMBIE, M.D., *Director***THE GEORGIA RAPID TREATMENT CENTERS FOR VENEREAL DISEASE**

Providing a most effective aid in the control of venereal disease, the U. S. Public Health Service, in collaboration with state and local health departments, has established throughout the nation a network of medical centers for intensive treatment of cases of infectious venereal disease.

Latest methods of rapid therapy, including the use of penicillin, are carried out in the management of syphilis and gonorrhea in these hospitals.

Georgia is fortunate in having two such centers located in this State.

The Southeastern Medical Center is located on Oatland Island about seven miles from Savannah, just off the Savannah Beach Highway, while the Piedmont Medical Center is located at 1 Milledge Road, Augusta.

These two institutions have been in operation since June 1943 and, to date, have treated approximately 6,000 cases of infectious disease.

Advancements in the treatment of venereal disease have been phenomenal. Rapid treatment of syphilis has been developed to the point where it is both effective and safe, and the long treatment period of some 70 weeks has been reduced to a few days. Gonorrhea, by use of penicillin, may be cured practically overnight.

Unfortunately, facilities required for the use of rapid syphilo-therapy are such as to render this modern measure unavailable in many localities. Intensive arseno-therapy necessitates hospitalization and laboratory control. The use of penicillin, though simple and safe, includes administration of injections every three hours day and night and, therefore, involves some form of domiciliary care. The limited amount of available penicillin precludes its general distribution to all treatment sources.

Establishment of the Georgia rapid treatment centers makes the most modern and effective therapeutic procedures available to persons with infectious venereal diseases.

From the public health standpoint, the orthodox weekly treatment schedule for syphilis presents two especially serious problems:

(1) Chemical quarantine is inadequate to protect others from being infected by the patient.

(2) Only a minority of patients complete treatment on a regular schedule.

Rapid treatment in an institutional environment offers an ideal solution of these two problems. Comparative figures show that 96 per cent of patients admitted to rapid treatment centers for syphilo-therapy complete adequate treatment as against 16 per cent of patients treated in the out-patient type of clinic.

This isolation of infectious cases during the period of infectiousness and returning them to their communities, no longer a public health menace, accomplishes the true public health objectives of venereal disease control.

Of considerable interest is the fact that the majority of admissions to the medical centers are on a purely voluntary rather than a quarantine basis. Discharged patients are enthusiastic in recommending the service and are influential in persuading others to avail themselves of the facilities of the centers.

Admission Policy

All cases of infectious venereal disease are eligible for admission to the nearest medical center. Patients may be referred by physicians licensed to practice medicine in Georgia as well as by local health departments. There are no restrictions concerning residence, race or sex.

Syphilis cases in the primary (chancre) stage, secondary (rash) stage, or with early latent syphilis of less than two years duration and having had not more than ten injections of an arsenical will be accepted. Cases of late syphilis, symptomatic or asymptomatic, are not eligible.

All cases of gonorrhea and chancroid are acceptable, and are accepted routinely.

Patients with advanced granuloma inguinale or lymphopathia venereum often present the problem of lengthy hospitalization and cannot be accepted except upon authorization by the medical officer in charge.

Any patient with a genital lesion may be referred for diagnosis and treatment.

A letter from the referring physician, showing diagnosis, laboratory and clinical findings, as well as any treatment given, should accompany the patient. Physicians may refer patients directly to one of the hospitals or referral may be through local health departments who will be glad to assist in such procedures.

Patients should be advised to get in touch with the hospital immediately upon arrival in Savannah or Augusta, as the case may be. Transportation from the station to the hospital will be provided.

The Southeastern Medical Center in Savannah is under the direction of Dr. Clarence A. Smith, telephone 3-4556.

The Piedmont Medical Center in Augusta is under the direction of Dr. Forest C. Hunter, telephone 3-7794.

All diagnostic aids for venereal disease management are available at the two centers. Patients with genital lesions are subjected to dark-field examination for *Spirocheta pallida*, smears for *Ducrey bacillus*, and skin tests for chancroid

(Continued on page 21)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1943-44

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Ruth Babin, Atlanta.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Frieda Grefe, Savannah.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 131 Forrest Ave., N. E., Atlanta. Phone WALnut 8911; residence, MAIn 7428.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACkson 7979.

GEORGIA NURSING IS AT THE NATION'S SERVICE

Among the highlights of the 38th Annual Georgia Conference on Nursing held December 4-5, 1944, at the First Methodist Church, Atlanta, was the visit of Miss Lucile Petry, director of the U. S. Cadet Nurse Corps. Miss Petry stated at a rally meeting to over 1,000 cadet nurses and the public, that the cadet nurses have saved the day for our civilian hospitals. She paid special tribute to cadet nurses as she urged them to assume full responsibility for the federal program which is giving them an education and career. "The Cadet Nurse, a Girl with a Future," was her snappy topic.

Mrs. Nan Cox Hare, nursing supervisor, T. V. A., from Chattanooga, Tenn., spoke at a luncheon sponsored by the Industrial Nurses Group on Tuesday, December 5, held at the Henry Grady Hotel. Mrs. Hare emphasized the need for better basic education as well as more post-graduate nurse education work for nurses in industry. "The nurse needs to have a clear knowledge of danger hazards in industrial work and work closely with the safety office in prevention programs," said Mrs. Hare.

Dr. Rufus Floyd Payne, director of Georgia's Health Panel, gave a pictorial review of the limited health facilities in Georgia, and explained in detail definite plans for expansion. He stressed the fact that nurses play a tremendous part in health and welfare of the State and asked for full cooperation from nurses. *The Georgia State Nurses' Association unanimously agreed to promote in all possible ways this forward movement.* Dr. Payne stated that Georgia has only 123 hospitals and that only 9 of these are accredited for internship. Of the 159 counties in Georgia, 86 counties have no general hospital beds; two counties have no physicians; only 59 counties have full-time health departments; 60 counties have only the public health nurse working with the regional health director.

Miss Lillian O. Nelson, president of the Georgia State Nurses' Association, presided over a dinner held December 4 in the Dixie Ballroom, Henry Grady Hotel, honoring Miss Petry. Dr.

Goodrich White, president, Emory University; Dr. Russell Oppenheimer, Emory University Medical School; Dean Tate of the University of Georgia; Dr. George Sparks of the University of Georgia Junior College, as well as Miss Petry and officers of the Association, spoke briefly of the establishment in Georgia of the two University Schools of Nursing; namely, Emory and the University of Georgia. Dr. White and Dean Tate both said that they were proud of the contributions the cadet nurses had already made to the University, and every effort is being made to give these students a broad and well-rounded education.

Special Actions Taken

Plans for the organization of the Georgia Association for Industrial Nurses were formulated.

The State Nursing Council for War Service will be reorganized and will establish a Post-War Planning Committee which will be in line with National Nursing Council for War Service Program.

The Georgia League of Nursing Education and the State Nurses' Association will extend a special invitation to the National Joint Counseling Committee of the American Nurses' Association and the National League of Nursing Education to establish regional headquarters at Atlanta.

Recommendations were adopted to foster legislation for auxiliary workers. This service is to be clarified to the public. Following licensure of auxiliary workers, steps are to be taken to encourage special schools for this training. An immediate campaign is to be undertaken to ascertain the number of auxiliary workers available to the public and the number needed.

Elections — G. S. N. A.

It was unanimously voted to retain the same officers for 1945. They are as follows: Lillian O. Nelson, president, Atlanta; Sister Mary Cornile, vice-president, Atlanta; Vera Mingledorff, second vice-president, Griffin; Mrs. Esther Watts, secretary, Columbus; Jane Van De Vrede, treasurer, Smyrna; directors: Alice Stewart, Augusta; Genevieve Garren, Atlanta; Frieda Grefe, Savannah; and Mrs. Lessie Cather, Atlanta, was elected to fill a vacancy as director. Mrs. Lucille Mur-

(Continued on page 19)

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

WOMAN'S AUXILIARY NEWS

Mrs. Edgar H. Greene of Atlanta, first vice-president and chairman of health education of the Woman's Auxiliary to the Medical Association of Georgia, writes interestingly to members on the health program for the state.

Today health education is of prime importance in the social welfare of the individual and his community.

A mobilization of community forces for the protection of civilian health is a necessary part of our home defense and an urgent responsibility for our future welfare.

The Committee on Health Education approves an active program, including the following subjects: Cancer, Nutrition, Tuberculosis, Venereal Diseases and Sex Education.

Cancer—It is very important for the layman to know a few facts concerning cancer, its nature, causes and control. Correct information and messages of hope can be given every family through the vast educational facilities of Georgia's cancer program.

Nutrition—Food is the substance of all life and good nutrition is the essence of well-being. Our understanding of the relation of nutrition to health is broadening with the assistance of research on many fronts. The medical authorities of our counties, state and nation, together with the American Red Cross, offer great aid in the nutrition program.

Tuberculosis—Tuberculosis continues to kill approximately 60,000 people annually in the United States. Most of these deaths could have been prevented. Every open case of tuberculosis puts into circulation germs which will infect others. War and tuberculosis are always partners. The cost to the government of the tuberculosis breakdowns from World I is already over one billion dollars. Since tuberculosis takes such a toll of life and money, let us stress the periodic check-up and chest x-ray suggestions of the medical profession.

Venereal Diseases—Wartime brings its great health problems, among which the dangerous and infectious diseases of syphilis and gonorrhea take their toll. Be prepared to help the public face this problem frankly and intelligently. Your local medical authorities, public health officers and American Social Hygiene workers have abundant educational opportunities to offer you through talks, pamphlets and movies. Education is the main hope for the eradication of venereal diseases.

Sex Education—The guidance of our children and youth depend upon the understanding and healthful presentation of facts to boys and girls. Sex education today means a bulwark of protection against the physical and mental cripples of tomorrow. It is the earnest desire of

the State Auxiliary to have each county auxiliary cooperate with the local school authorities in their approved program of sex education in the high schools.

Mrs. J. Harry Rogers, chairman of Public Relations for the Woman's Auxiliary to the Medical Association of Georgia, has suggested the following program for this year:

As we are an auxiliary, we must be guided in all our public relations work by the members of our advisory committee from the Medical Association of Georgia. I strongly feel that our function in this important work is to let the lay public learn, through us, the things which the medical profession wishes to have stressed and, accordingly, I think our first and most important objective in public relations is to carry their message to the public through lay groups.

Health education, always a primary objective of ours as a medical auxiliary, is even more important during these times when people are living under abnormal conditions, and with food rationing, and it should be stressed more than ever.

A member of our advisory committee has suggested that we have a state-wide speakers' bureau to secure speakers for auxiliary meetings, clubs, P.-T. A. groups, etc., to let the public know what the doctors are doing and plan to do for medicine and health. By this state-wide committee an interchange of speakers should be possible, these to come from auxiliaries, medical societies and lay groups. Therefore, the public relations chairman is asking each county president to appoint a speakers' bureau chairman from her auxiliary.

In public relations, we can do untold good, as individuals, in presenting the Wagner-Murray-Dingell bill to the public, with all its true ramifications. Every point of this bill should be at your finger tips and we should always be ready to give intelligent answers to any questions about it. We should also have speakers from each auxiliary ready to talk on this subject before any group wishing to hear it discussed.

A primary objective during these war years should be contacts with the doctors serving in the armed forces in our areas, and with their families. One of the reasons for an auxiliary is to promote closer association of doctors and their families with others of the profession and I think we can do inestimable good in making service doctors and their wives become a part of our community. To me, who knows from personal experience, a doctor and his wife always wants to be considered that, and yet too little stress is placed upon making them feel a medical part of the community in which they serve.

We should, as individuals, cooperate in all forms of

war services, though there may be times when we cannot do things as a group. But in these times I think we should always let everyone know that we are doctors' wives and as such are offering our services. There is a great need for nurses' aides and I know of no better way in which we can serve, both the public and the medical profession, than in taking the Red Cross nurses' aide course, and in working in the hospitals all that we possibly can.

We should urge the sale and distribution of *Hygeia*, the magazine published by the American Medical Association, and try to make the public realize the worthwhile health information that is contained in this periodical. We should also urge the public to listen to those radio programs that are sponsored by the American Medical Association.

Baldwin County

The December meeting of the Baldwin County Medical Auxiliary was held with Mrs. C. H. Richardson on December 11. The activities reported for the past quarter were: One bond bought in last drive, gifts sent to the hospital at Camp Wheeler for Christmas; dues paid for 1944-45; several new subscriptions for *Hygeia*. Chairman for gathering needed articles for Robins' field reported a generous response.

Report was made that Mrs. Emory Clay of Macon was elected district president and Mrs. Sam Anderson, Milledgeville, was elected president-elect at the Sixth District meeting held in Macon, December 7. The importance of being members of the League of Women Voters was discussed. A social hour was enjoyed.

Fifth District

The Woman's Auxiliary to the Fifth District Medical Society held its semi-annual meeting at the Academy of Medicine in Atlanta recently. Mrs. Shelley C. Davis, president, presiding. Other officers are Mrs. Frank Boland, Sr., vice-president and Mrs. L. Harvey Hamff, secretary. Miss Emily Woodward of *The Atlanta Journal* talked most interestingly of her recent visit to England. Prior to the business meeting, the auxiliary members enjoyed a delightful dinner served by the Fifth District Medical Society.

LETTER FROM A DOCTOR'S WIFE

The following short letter from a doctor's wife may be of interest:

"A half year ago, my husband ordered *Hygeia* for me. He hoped it would help me to understand his medical profession better.

"The first few issues I received, I laid aside, lacking time and interest for them. Soon though, in my effort to get adjusted to being a doctor's wife, I began to read some of the articles and found them quite interesting.

"With every issue, after that, my interest in the Health Magazine grew and by now, I hardly miss a line of it. *Hygeia* has given me a better appreciation of my husband's work and the problems of other physicians."

THE YEAR 1945

(Continued from page 15)

gets the best medical care in the world today.

True, changes are taking place but perhaps not as speedily as some of us think. For example, on other pages of this JOURNAL is printed in full a proposed hospital bill. This and other medical legislation will be offered at the coming session of the General Assembly of Georgia, and all of it has been designed to help all of the people. But will our people adopt our proposals? May we, then, in the year 1945 have with our blood, sweat and tears, normal progress, progress not only with the war but with all medical activities which will help the most people.

(The bill did not get to first base. Its publication will be postponed—Ed.)

NURSES

(Continued from page 17)

phy, Albany, was elected chairman of the Nominations Committee.

Georgia League of Nursing Education

Julia Miller, president, Atlanta; Mrs. Eva S. Tupman, president emeritus, Atlanta; Elizabeth McClellan, vice-president, Atlanta; Julia Mariani, secretary, Atlanta; Florrie Lee Erb, Atlanta; director, Ruth Babin, Atlanta; educational secretary, Mrs. Durice Dickerson Hanson, Atlanta; ex-officio members: Mrs. Gladys L. Garland, Atlanta; Mrs. Ada G. Bussey, Pine Mountain Valley; Lillian O. Nelson, Atlanta.

Private Duty Section, G. S. N. A.

Mrs. James W. Geeslin, chairman, Atlanta; Mrs. Lucille Murphy, vice-chairman, Albany; Mae White, secretary, Thomasville.

Georgia Association for Industrial Nurses

Flo Beck, president, Chocoma; Mrs. Adelaide Stewart, vice-president, Atlanta; Mrs. Elizabeth Blakewood, secretary, Savannah; Mrs. Edith McG. Hall, treasurer, Macon.

State Organization for Public Health Nursing

Mrs. Gladys L. Garland, president, Atlanta; L. Carey Jones, vice-president, Atlanta; Gwen Dekle, secretary, Atlanta; Caroline Tillinghast, treasurer, Albany; nurse members: Louise Abercrombie, Millen; Mrs. Merle K. Lott, Atlanta; general members, Mrs. Charles Center, Atlanta; nominating committee: Gertrude Shepherd, Gainesville; Adele Thaxton, Atlanta.

State Nursing Council for War Service

Mrs. Lessie Cather, Atlanta, was elected chairman, and all other officers and members remain the same. There is no change in this group except for filling of vacancies. Mrs. Mildred Pryse is executive secretary for the Council. Telephone MAin 7428. Mrs. Durice Dickerson Hanson is executive secretary for the Georgia State Nurses' Association.

PHYSICIAN VETERANS' EDUCATION IS PROVIDED FOR BY G. I. BILL

Physician veterans of this war are eligible to obtain graduate education in the postwar period under the provisions of the so-called "G. I. bill," which entitle them to payment of tuition and also a subsistence allowance while taking their courses. A conference with officials of the Veterans Administration has disclosed, it is reported in *The Journal of the American Medical Association* for November 11.

The information, which, as *The Journal* points out in the same issue, is of the "greatest importance to all physicians now serving with the armed forces," is contained in a preliminary report of the Subcommittee on Postwar Education of Physician Veterans, of the American Medical Association's Committee on Postwar Medical Services.

The Journal further emphasizes the importance of the report by pointing out that "Preliminary reports on the results of the questionnaire sent by the Committee on Postwar Medical Service to all physicians in the armed forces indicate that the majority of physicians wish graduate education, including short and long courses, in the postwar period."

The report points out that it was the opinion of the official in charge of the administration of that phase of education of veterans that the approved schools and hospitals in which the physician veterans would be taking their graduate training can be regarded as institutions eligible for recognition as educational centers in which such educational benefits might be provided under the law.

The conference brought out the fact that the law, as interpreted, makes it possible for any physician now in any of the branches of the service and who has been on active duty for more than ninety days to be eligible for any of the benefits provided by the law.

In addition to the tuition and fee benefits provided under the law, physicians coming under the provisions of the act also will be paid a subsistence allowance of \$50 per month if without a dependent or dependents or \$75 per month if he has a dependent or dependents.

The tuition and fee benefits and the subsistence allowance for physicians engaged in such courses will be subject to limitations which depend on the duration of service and similar factors.

ARMY MALARIA CONTROL THREE-FOLD PROBLEM

The Army has made great progress in the control of its No. 1 disease hazard, malaria, according to Brigadier General James S. Simmons, Chief of the Preventive Medicine Service, who described Army methods of malaria control to The Military Surgeons meeting in New York City. In the Army, the problem has two aspects, General Simmons said—control in base areas and protection of troops in combat. The first is primarily mosquito

control, and specially trained personnel are required to produce effective results. The malaria control organization in the Army Medical Department includes medical officers trained in malariology, and small survey and control units headed by parasitologists, entomologists and sanitary engineers.

The second aspect—protection of troops in forward and combat areas—depends upon individual measures of protection in addition to mosquito control according to General Simmons, and strict malaria discipline must be established and enforced. Soldiers must be drilled in the use of repellents, sleeping nets, protective clothing and insecticide sprays in the same way they are trained to use combat weapons.

Concerning the third aspect—the possible spread of malaria in this country by returning soldiers—General Simmons said that members of the armed forces who have had malaria will be given sufficient treatment to render them free from demonstrable parasites before they are discharged. In addition, men who have had malaria or served in malarial regions are advised to seek prompt medical attention and have a blood smear for malarial parasites in case of illness with fever.

However, he added, prevention of malaria in this country, as elsewhere, depends essentially upon the control of the malaria carrying mosquito.

VIRUS TYPE EQUINE ENCEPHALOMYELITIS

All three types of equine encephalomyelitis viruses known to be present in the Western Hemisphere are capable of producing fatal encephalitis in man according to Colonel Raymond Randall, V. C., of the Army Veterinary School at Washington, D. C. In a paper presented at the annual meeting of the Association of Military Surgeons, Colonel Randall pointed out that the relatively high mortality rate of the human disease emphasizes the importance of this horse disease from the public health standpoint.

In 1941 more than 3,000 human cases were reported in the United States and Canada. Most of them occurred in North Dakota, South Dakota, Nebraska and Canada, North Dakota having the highest incidence with 1,080 cases and 96 deaths. Cases were also reported from California and Washington. The mortality rate among the human cases varied in different areas from 8 to 20 per cent, adult male farm workers having the highest incidence. This is in contrast with the Eastern type infection which in the outbreaks thus far recorded was predominantly a disease of children and had a mortality rate of approximately 75 per cent. In many instances during the midwestern epidemic of 1941 the Western type encephalomyelitis virus was isolated and it appears that the St. Louis encephalitis virus played a very minor role in the outbreak.

The evidence is ample, Colonel Randall said, that equine encephalomyelitis is transmitted by insects, particularly mosquitoes, and its control involves anti-mosquito measures. Horses and mules may be protected against the disease by the annual administration of chick tissue vaccines. A vaccine suitable for human use has been developed in the Army Veterinary School, Colonel Randall said, and can be made available if indications for its use should develop.

NURSES NEEDED

"One thing I know"—reports Mrs. Frances Payne Bolton in the January 1945 *American Journal of Nursing*, after a two months' visit to hospitals of England and areas of France which have been liberated—"Were I fit and young enough and *trained* nothing would keep me from meeting the greatest challenge American life has ever given women who are nurses. If I were trained in nursing or physical therapy or as a nurse's aide and unable to go overseas I would apply for service in our hospitals here to which these men of ours are coming by the thousand. I wouldn't miss the experience altogether. I wouldn't go into it just because of the terrible need our wounded have for care: I would do it partly because I know I couldn't face myself in the years that inevitably come, when one looks back on life, if I had let the opportunity to live deeply pass me by.

"Yes, I have had a rich experience but an infinitely richer one awaits you who are trained, you who are young. The Army, the Navy, and the veterans' hospitals, all of them need you, but the Army most of all. I say 'the Army'! But it is the men that need you—your men—who have thrown themselves against the most fiendish enemies that decent, clean, wholesome living has ever known. It is your own men who look to you consciously or unconsciously knowing that wherever women are, trained women most of all, there can be found the new courage, the fresh hope, and the renewed faith they need to carry on the war and to face the hard road back to normal living."

GEORGIA'S VENEREAL DISEASE

(Continued from page 16)

and lymphopathia venereum. Smears for examination for Donovan bodies are made in cases of suspected granuloma inguinale.

Cultures for gonococci are used for diagnostic purposes as well as for determination of cure.

Gonorrhea cases are dismissed following the securing of negative cultures.

All cases of syphilis admitted receive spinal fluid study before dismissal. Follow-up blood tests are requested on dismissed syphilis cases, both as evidence of cure and for evaluation of various treatment schedules. Positive blood tests usually do not reverse for three or four months following intensive therapy.

The advantages of rapid methods of therapy are attested by the definite national trend in this direction. It is hoped that support of the rapid treatment centers by practicing physicians and local health departments will be such as to justify continuance of these facilities on a permanent basis.

Physicians are cordially invited to visit the medical centers.

JOHN M. WALTON, M.D., *Director*,
Venereal Disease Control Service.

The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 8-11, 1945.

POSTWAR PLANS FOR MENTAL HOSPITALS

The necessity for vastly expanded facilities to treat mentally disabled patients now and in postwar years lent special significance to the consideration of mental hospitals and technics at the 46th annual convention of the American Hospital Association, held in Cleveland, Ohio, during the first week in October, this the third wartime conference of the Association, a non-profit corporation composed of hospitals in almost every city in the United States.

The Mental Hospitals' Section of the convention was under the chairmanship of Dr. Frederick MacCurdy, commissioner of the Department of Mental Hygiene of the State of New York. Dr. Clarence H. Bellinger of the Brooklyn State Hospital, Brooklyn, N. Y., addressed the section on *Organization and Management of Shock Therapy Service*.

Mrs. Laura Fitzsimmons of the research division of the American Psychiatric Association in New York City spoke on *Newer Trends in Psychiatric Nursing. What of Postwar Construction for Mental Ill Patients?* was the subject of the talk by J. Fremont Bateman, M.D., medical superintendent of the Columbus State Hospital, Columbus, Ohio. A round table discussion was held at the conclusion of the speeches.

Mental hospitals have been affected even more than general hospitals by wartime conditions. Their staffs, too, have been depleted by the armed services and industry, and in addition most mental hospitals receive no voluntary help. Peacetime figures from 1933 showed 376,873 patients in public institutions. This total has since increased, and the situation is further aggravated by wartime hindrances to necessary expansion of buildings and equipment for mental care.

Postwar construction of 48,575 new beds in addition to building expansion in non-federal mental hospitals may be expected at a cost of \$192,341,080, according to a survey conducted by the Council on Government Relations of the Association. A 1943 census of mental hospitals showed a national bed count of 606,097.

The federal government has indicated that it will ask civilian public and voluntary hospitals to cooperate in the hospitalization and treatment of veterans. In addition to its machinery for the rehabilitation of the war-injured, it has made provision for certain civilian rehabilitation through the Barden-LaFollette Act, to be administered through the states with both state and federal funds. Civilian hospitals approved by the American College of Surgeons are to form the basis, for the present, of this program. An appropriation of 500 million dollars has been made by the Senate for hospitalization of veterans, and the total cost of rehabilitation of war-disabled civilians will be paid by the federal government.

As men and women in service return in increasing numbers to this country and are discovered to require mental rehabilitation, a great number of America's hospitals and health centers will be mobilized to care for them. All existing facilities for this treatment and the care of mental cases are expected to be utilized and to cooperate for the restoration of the mental as well as the physical health of our people.

Plans for achievement of this necessary goal were formulated at this convention, where member hospital administrators have a yearly opportunity to exchange technical and administrative information. The Association will coordinate any plans or actions that are decided upon and offer any assistance to individual members or communities to execute their program.

UNUSUAL BRAVERY OF THE MEDICAL CORPS

The heroic and self-sacrificing acts of many men of the medical corps have been repeatedly noted under Medicine and the War in *The Journal*. Feats of combat pilots, gunners, submarine crews, pioneer troops and tank crews are frequently vividly described in the newspapers. Physicians with the armed services are daily performing great and small acts of heroism in the care of the sick and injured. Often their work is unnoticed beyond the small group in which they regularly do their professional duties. A War Department release of November 19 announces the award of the Silver Star to five men, of whom three were members of the Medical Corps of the Army of the United States. Among twenty-two men awarded the Bronze Star Medal, seven were medical officers and eight enlisted men of the Medical Department. Nearly all of the citations were given for the high devotion to duty displayed by medical officers in going to the aid of wounded soldiers in the face of intense enemy infantry and artillery fire with utter disregard for their own personal safety. This record all doctors may share with pride.—*The Journal of the American Medical Association*.

HEAD-WOUND GAS MASK NOW IN PRODUCTION

A gas mask to protect head wound patients from war gas has been developed by the Chemical Warfare Service at the request of the Medical Department, and is now in production, the War Department has announced.

The mask is the first such device especially designed to protect patients with bandaged heads, faces, or jaws. It consists of a silk-like plastic hood to which an air-purifying canister and an outlet valve are attached. A flexible window across the eyes provides clear vision. Air is drawn into the mask by the ordinary breathing of the wearer.

The mask is pulled over the head like a sack, and experiments at the Medical Research Laboratories have shown it to be comfortable to the wearer as well as efficient.

FAMILIES TO RECEIVE REPORTS FROM OVERSEAS HOSPITALS

Under a new plan adopted by the War Department, the family of a wounded or seriously ill soldier is to be kept informed of his condition by the overseas hospital. The first letter dispatched to the family will contain a brief non-technical description of the soldier's wounds or the nature of his illness. A post card on the soldier's condition will then be mailed his family every fifteen days. In return the family is urged to send the overseas patient a "message of cheer" at least once a month.

NEWS ITEMS

Members of the Medical Association of Georgia who were recently accepted into fellowship of the American College of Surgeons were: Dr. Franklin D. Edwards, Columbus; Dr. Albert L. Evans, Atlanta; Dr. Joseph C. Hayward, Atlanta; Dr. Hughes B. Jenkins, Donaldsonville; Dr. G. Frank Jones, Jr., Augusta; Dr. Robert W. McAllister, Macon; Dr. Ralph B. McCord, Rome; Dr. Fred F. Rudder, Atlanta; Dr. John K. Stalvey, Jr., Savannah; and Dr. Sam M. Talmadge, Athens.

Plans are being made by Emory University for an Ophthalmologic Seminar to honor the memory of Dr. Abner Wellborn Calhoun, M.D., LL.D., who was born April 16, 1845. He was the first Professor of Ophthalmology of Emory University, and a pioneer in Southern ophthalmology. The program will be April 19-21, 1945. All physicians interested in ophthalmology are invited to attend as guests of Emory University. The guest speakers will be: Dr. W. L. Benedict, Dr. John Dunnington, Dr. Harry Gradle, Dr. Parker Heath, Dr. Walter I. Lillie, Colonel Derrick Vail and Dr. Frank Walsh.

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, Jan. 2, 1945. Appointment of committees, and "Clinical Cases" were discussed.

The Fulton County Medical Society held its anniversary banquet at the Biltmore Hotel, Atlanta, Jan. 4, 1945. Mr. O. B. Keeler of *The Atlanta Journal* was guest speaker.

Miss Frances Atwater, formerly advertising manager of Lederle Laboratories, Inc., New York City, joined the sales promotion staff of Wyeth, Incorporated, Philadelphia, as executive assistant to Mr. Stuart V. Smith, director of sales.

The Georgia Baptist Hospital staff dinner meeting was held December 19 in the Nurses' Home dining room. The Clinicopathologic Conference meeting was held in the Sheffield Auditorium.

The Tulane University of Louisiana School of Medicine, Department of Graduate Medicine, announces the following review courses: "Tropical Medicine and Parasitology," Jan. 15-27 and April 16-27, 1945. Special courses: "Metabolic and Nutritional Disturbances," Feb. 5-10, 1945. "Recent Advances in Therapy," March 5-10, 1945. "Diagnosis and Treatment of Neoplasia," April 30-May 4, 1945. "Genito-Urinary Diseases," May 7-11, 1945.

The Sixth District Medical Society held its winter meeting at Ridley Hall, Macon, Dec. 7, 1944, with the following scientific program: "Four Year Report on Per Oral Endoscopy," Dr. William Barton, Macon; "A Year's Experience With Penicillin Therapy," Major Milford B. Hatcher, Thomasville; "Treatment of Ulcers With Blood Paste," Dr. D. C. Sirmons, Macon; "Post-War Public Health Expansion Program," Dr. C. L. Ridley, Macon; and official remarks by Dr. Cleveland Thompson, Millen, president of the Medical Association of Georgia.

Officers: President, Dr. C. S. Jernigan, Sparta; Vice-

President, Dr. B. L. Helton, Sandersville; and Secretary-Treasurer, Dr. A. M. Phillips, Macon.

Dr. Mary J. Erickson has resigned as pathologist of the John D. Archbold Memorial Hospital, Thomasville. She has been with the hospital since 1925 but will now enter private practice in Thomasville in the field of pathology.

Mrs. Rhea Carnes Hayes, R.N., who has been in charge of the Department of Anesthesia at the John D. Archbold Memorial Hospital, Thomasville, since 1925, has resigned, and no successor has as yet been named.

The John D. Archbold Memorial Hospital, Thomasville, have added the following doctors to their staff: Dr. John D. Mohley from Pelham; Dr. Joseph Winfred Harner, Jr., from University Hospital, Augusta, assistant surgeon; and Dr. R. Mosteller from Wilmington, N. C., pathologist.

The Georgia Division of Vocational Rehabilitation has named a medical advisory committee and an executive medical committee. Named to the advisory committee were: Dr. C. C. Aven, Atlanta; Dr. V. P. Sydenstricker, Augusta; Dr. Joseph Gaston, Columbus; Dr. Jeff L. Richardson, Atlanta; Dr. H. M. Cleckley, Augusta; Dr. Ben Hill Clifton, Atlanta; Dr. Edgar F. Fincher, Atlanta; Dr. Julian K. Quattlebaum, Savannah; Dr. Ralph H. Chaney, Augusta; Dr. Guy O. Whelchel, Athens; Dr. Frank K. Neill, Albany; Dr. Herschel C. Crawford, Atlanta; Dr. A. R. Rozar, Macon; Dr. Edgar H. Greene, Atlanta; Dr. John T. McCall, Rome; and Dr. J. W. Landham, Atlanta.

Elected to the executive committee were: Dr. Thomas P. Goodwyn, chairman; Dr. Edgar H. Greene, Dr. Ben Hill Clifton, Dr. Jeff L. Richardson, Dr. Edgar F. Fincher, Dr. Herschel C. Crawford and Dr. C. C. Aven, all of Atlanta.

The division selected and employed a medical consultant, Dr. Thomas P. Goodwyn, to advise the committee on all important cases.

Dr. C. C. Aven, Atlanta, attended the meeting of the Southern Chapter of the American College of Chest Physicians, held conjointly with the Southern Medical Association at St. Louis. The following officers were elected: President, Dr. Alvis E. Greer, Houston; First Vice-President, Dr. C. C. Aven, Atlanta; Second Vice-President, Dr. Paul A. Turner, Louisville; and Secretary-Treasurer, Dr. Benjamin L. Brock, Waverly Hills, Ky.

The Muscogee Medical Society recently held its meeting at Cherokee Lodge, Columbus. Dr. J. E. Walker introduced the speaker, Dr. Frederick W. Wilkinson, past president of Alabama State Medical Society, Montgomery, Ala. His subject: "Focal Infection." Discussion: Dr. G. J. Dillard, Dr. W. E. Mayher, Jr., and Dr. G. S. Murray. The following officers were elected: President, Dr. Bruce Threatte; Vice-President, Dr. O. D. Gilliam; and Secretary-Treasurer, Dr. Leon Lapidis.

The Glynn County Medical Society, Brunswick, held its annual meeting at the City Hospital, December 4.

The following officers were elected: President, Dr. T. V. Willis; Vice-President, Dr. M. E. Winchester; and Secretary-Treasurer, Dr. Thomas W. Collier. Dr. Erle T. Newson, St. Simons, was welcomed as a new member.

Correction. Unfortunately in the Fulton County roster Dr. Marion McH. Hull of Atlanta was listed as deceased. Dr. Hull is alive and in active practice every day.

OBITUARY

Dr. Claude McKinley Burpee, aged 47, leading Augusta physician, died at his residence, 1127 Monte Sano Avenue, Augusta, Dec. 2, 1944. A native of Athens, he was the son of the late Robert Alonzo and Lula Pitts Burpee. He was graduated from the University of Georgia School of Medicine in 1922. For three years he served as resident physician at the University Hospital, Augusta, before going to St. Louis for post-graduate work. Dr. Burpee was a recognized authority on pediatrics and was pediatrician-in-chief at the University Hospital at the time of his death. He was a member of the Richmond County Medical Society, the Medical Association of Georgia, the honorary medical fraternity, Alpha Omega Alpha; Alpha Kappa Kappa social fraternity; and St. Mary's-on-the-Hill Catholic Church.

He is survived by his wife, Mrs. Lucile McLeod Burpee; a son, Claude McLeod Burpee; three daughters, Barbara, Rosemary and Elizabeth Ann Burpee; his mother, Mrs. Lula Pitts Burpee, Athens; six brothers and two sisters. Funeral services were held at St. Mary's-on-the-Hill, Augusta, with Father Thomas J. Brennan officiating.

Dr. Marcus F. Carson, aged 73, died at his home in Griffin, Nov. 26, 1944. He was born in Holly Springs, Miss. His parents were George Lumpkin Carson and Mrs. Georgiana Westbrook Carson. Dr. Carson was graduated in the class of 1894 from the Tulane University of Louisiana School of Medicine, New Orleans. He moved to Griffin and established himself in the practice of medicine. After a few years he went to London, England, where he spent a year at Guy's Hospital. He then returned to Griffin to resume his practice of medicine and surgery.

Dr. Carson was a member of the Spalding County Medical Society, the Medical Association of Georgia and the First Presbyterian Church, Griffin. He is survived by his wife, Mrs. Jacksonia Mills Carson; three sons, Marcus F. Carson, Jr., New York City; George Mills Carson, with the Army Air Force in France, and Thomas Mills Carson of Griffin. Funeral services were held from the chapel of Frank S. Pittman Funeral Home, with Rev. L. W. Topping officiating. Interment was in Oak Hill Cemetery.

Dr. Norman V. Collins, aged 55, died at his home, 526 West Solomon St., Griffin, Nov. 24, 1944. He was the son of the late Ben and Mary Jackson Collins. Dr. Collins was a graduate of the 1910 class of the University of Georgia School of Medicine, Augusta, and a member of the Baptist Church. Survivors are his wife, Mrs. Gladys Ward Collins; one son, William Howard Collins, Merchant Marine, serving in the Pacific Area;

two daughters, Mrs. M. E. Norton, Griffin, and Miss Louise Collins, Chattanooga, Tenn.; two brothers, four sisters and two grandchildren. Funeral services were held at Haisten's Chapel, with Rev. Byron M. Wilkinson and Rev. J. D. Booth officiating. Interment was in Oak Hill Cemetery.

Dr. Thomas Frederick Guffin, aged 69, of 409 South Street, East Point, general practitioner and a member of the staff of Georgia Baptist Hospital, died Nov. 22, 1944. Dr. Guffin graduated from the Atlanta College of Physicians and Surgeons in 1912, now Emory University. He was an honorary member of the Fulton County Medical Society, the Medical Association of Georgia, and was affiliated with the Inter-City Civitan Club and the East Point Presbyterian Church. He is survived by his wife, the former Miss Louise Conkell, a daughter, Miss Catherine Louis Guffin; and a son, Marine Captain Fred Guffin, in the western Pacific. Funeral services were held at the chapel of Howard L. Carmichael, and interment was in West View Cemetery.

Dr. Herman William Hesse, aged 68, died at his residence, 112 Jones St., East, Savannah, Nov. 24, 1944. He was graduated from the University of Pennsylvania School of Medicine, Philadelphia, in the class of 1900. Dr. Hesse was not only a prominent physician but was a leader in educational and civic affairs of Savannah. He was a member of the Chatham County Medical Society (the old Georgia Medical Society), the Medical Association of Georgia; was past president of the Kiwanis Club; and a member of the Lutheran Church of the Ascension, where he served as deacon and member of the church council. He is survived by his wife, Mrs. Mattie Wilfert Hesse; a son, Herman W. Hesse, Jr., of Savannah; a daughter, Marian Hesse Galloway, Ph.D., Charleston, Ill.; a brother, Dr. J. W. Hesse and a sister, Miss Annie Hesse, also of Savannah. Funeral services were conducted at the residence, 112 Jones St., East, by the Rev. C. A. Linn, pastor of the Lutheran Church of the Ascension, with interment in Bonaventure Cemetery.

Dr. William H. F. Rhyne, aged 81, died at his home in Lafayette, Dec. 1, 1944. A prominent Walker County physician for 31 years after graduating from Vanderbilt University School of Medicine, Nashville, Tenn.. Dr. Rhyne retired in 1924 and since that time had devoted his time to managing farm and real estate interests. Surviving, besides his widow, are three daughters, Mrs. M. Neil Andrews, Mrs. H. E. Center and Mrs. M. A. Ramsey; three sons, John F. Rhyne, Rossville; W. T. and J. T. Rhyne, Lafayette; and two sisters. Funeral services were held at the First Methodist Church, with the Rev. L. B. Lynn, the Rev. W. E. Storey and Taylor Morton officiating. Interment was in the Lafayette Cemetery.

Dr. William Farquhar Shallenberger, aged 63, one of the best-known gynecologist and obstetricians in the South, died unexpectedly at Piedmont Hospital, Atlanta,

Dec. 16, 1944. Dr. Shallenberger was born July 25, 1881, the son of the late Frank and Emma Shallenberger of Greensburg, Pa. He was graduated from Washington and Jefferson College, in Pennsylvania, in 1903, and from the Johns Hopkins University School of Medicine, Baltimore, in 1907. He was an honor student at Johns Hopkins and received appointment as an intern in Johns Hopkins Hospital. Later he served as surgeon at the Hospital for Women of Maryland, at Baltimore. Coming to Atlanta to live in April, 1911, Dr. Shallenberger soon established a reputation in his chosen field of gynecological, obstetrical and abdominal surgery.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the Southern Medical Association, the Southern Surgical Association, the Southern Interurban Gynecological and Obstetrical Society, the Phi Delta Theta fraternity, the Alpha Omega Alpha honorary medical fraternity, and an honorary member of the Alpha Kappa Kappa medical fraternity.

At the time of his death Dr. Shallenberger was a member of the staffs of Piedmont Hospital and St. Joseph's Infirmary. At one time he was also chief of the obstetrical and gynecological service at Grady Hospital. He was also an active member of the First Presbyterian Church. Surviving are his wife, the former Miss Laura Boyd, of Savannah, and a daughter, Mrs. Allison Gossett. Funeral services were held at Spring Hill, with Dr. William V. Gardner officiating. Private burial in West View Cemetery.

Dr. James R. Wells, aged 72, physician at Stone Mountain for many years, died Jan. 1, 1945. A son of the late Captain G. R. Wells and Eliza Jane Hardman Wells, pioneer Stone Mountain residents, Dr. Wells was an 1887 graduate of the Emory University School of Medicine, Atlanta. He practiced medicine with Dr. Willis Westmoreland before moving his office to Stone Mountain. Survivors include his daughter, Mrs. Robert L. Herring, Decatur; a granddaughter, Mary Henrietta Herring, Decatur; and a sister, Miss Mary Wells, Stone Mountain. Funeral services were held at the residence on Ridge Avenue, with the Rev. D. T. Buice and the Rev. Mr. Sweatnam officiating. Interment in Stone Mountain Cemetery.

BORDEN AWARDS

"For outstanding achievement in research in nutrition of infants and children," Dr. Harry Gordon, assistant professor of pediatrics and Dr. S. Z. Levine, professor of pediatrics, at the Cornell University Medical College were joint recipients of the first annual Borden Award to be administered by the American Academy of Pediatrics. Presented at the Academy's Wartime Conference on Child Health in St. Louis, Missouri, the award was made for metabolic studies on the nutritional requirements of premature and full-term infants. These studies contribute a physiologic basis for individualized feeding.

The Borden Awards which carry with them a commemorative gold medal and \$1,000 were established in 1937 to encourage and give recognition to scientific research in the fields related to the food industry. They are administered by seven scientific associations.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, February, 1945

Number 2

CLINICAL ASPECTS AND TREATMENT OF CUTANEOUS CANCER

WM. L. DOBES, M.D.

Atlanta

LT. PHILIP H. NIPPERT

MC - V(S) USNR

It is well known that the farther south one goes the incidence of skin cancer increases. Skin cancer is a common ailment in Georgia and its complications are generally underestimated. The death rate from skin cancers and their metastases is comparatively high, and frequently the physician as well as the layman are to blame. Early as well as late malignant involvement of the skin is frequently belittled by the patient because there is no pain, the growth is slow, and usually the lesion appears innocent to the individual who has observed it daily for many months or years.

The appearance of early cancer of the skin is frequently confusing even to the physician and many of them are diagnosed as moles, warts, fibromas and other benign tumors. Because of misdiagnoses, many tumors are treated ineffectively or not treated at all. They continue to increase in size with destruction of the surrounding tissues; many metastasize before treated.

Diagnosis

Excluding melanomas, the skin cancers may be placed into two general types: the basal-cell carcinoma and the squamous-cell carcinoma. With these Georgia physicians are most frequently confronted.

The basal-cell carcinoma usually begins as a minute elevated tumor of waxy or pearly appearance which is frequently surrounded by dilated capillaries. There is a

history of long duration, usually of years. The tumor may become ulcerated and the punched-out lesion is referred to as a rodent ulcer. The growth has a tendency to extend and destroy considerable local tissue and indeed is even capable of destroying adjacent cartilage, bone and deep tissues. Metastases are extremely rare, although exceptions with conclusive proof have been reported in the medical literature.¹

The morphea-like basal-cell carcinoma which resembles scleroderma, and the psoriasiform basal-cell carcinoma which clinically resembles psoriasis, are comparatively rare, and therefore a clinical diagnosis of this group of basal-cell carcinoma is made with a high degree of accuracy.

The squamous-cell carcinoma in its early stages does not present a characteristic picture. The lesion may appear as a minute elevated papule which may be papillomatous or verrucous. It may be preceded by a keratosis. Sometimes a small reddish or yellowish, circumscribed nodule is present, from the center of which projects a horny spike. Crusting and superficial ulceration usually appear within a few weeks or a few months. The base is always sharply defined and more or less indurated. As the tumor increases in size the surface may be either ulcerated, flat, or covered with papillomatous, cauliflower-like vegetations, from which exudes a foul-smelling purulent or sanguinous fluid. The edges of the tumor may be everted and undermined. Connective tissue, cartilage, periosteum and bone are attacked with equal impartiality.

Metastases are common in the squamous-cell carcinoma. Extension to the regional lymph nodes occurs at an early date and the patient may succumb to metastases unless properly treated. Because of these early metastases a biopsy should always be made on any suspicious lesion.

Etiology

The etiology of cancer is still unknown. It is believed that malignancy is a universal cell potentiality. Any cell has inherent in its make-up the potentiality for unlimited or uncontrolled growth, the degree of which is determined largely by hereditary and predisposing factors. Too often cancer has no respect for race, age, or sex; however, we do find skin cancers more common in certain types of individuals. Blondes are better subjects than brunettes, and lightly pigmented, freckled, rough, rather dry skin is more likely to develop cancer. The high incidence in the Southern states is believed to be due to the greater exposure to actinic rays. This may be considered as one of the many carcinogenic agents. Weather exposed parts of the body (the face, neck and hands) are chiefly involved, although lesions may appear on parts of the body usually covered by clothing. The so-called sailor's skin and farmer's skin, which is characterized by dryness, freckling and keratoses, is frequently referred to as skin-cancer-skin.

Treatment

In the treatment of skin cancer the cosmetic result is of secondary importance although worthy of serious consideration. It is necessary to select a method of treatment which will be most effective in the destruction and eradication of the diseased tissue. If there is a method that will accomplish this purpose and at the same time give a superior cosmetic result, such treatment will constitute the method of election. The usual accepted methods of treating skin cancer are:

1. Surgical
 - A. Scalpel
 - B. Curettage
2. Thermic
 - A. Cautery
 - B. Electrodesiccation
 - C. Electrocoagulation
 - D. Cutting current
3. Irradiation
 - A. Roentgen rays
 - B. Radium
4. Chemical
 - A. Acid nitrate of mercury
 - B. Arsenical and zinc pastes

It is necessary to remember that all skin

cancers have a tendency to recur unless completely eradicated. The best method or combination of methods must be selected for each lesion. The method selected depends on the size, location, and type of lesion, whether previously treated and the method used; the age, physical condition, and sex of the patient. The final success depends not on the method used but on the skill with which it is used to eradicate all cancerous tissue. Early diagnosis is of great value. Ill advised surgery may cure the skin cancer but also cause unnecessary deformity. Over-zealous roentgen and radium irradiation is not only deforming but may be dangerous. Squamous-cell carcinomas may develop in sites of a radiodermatitis. These cancers must be removed surgically. Surgical treatment is also required on skin carcinomas that develop in such skin diseases as xeroderma pigmentosa, acrodermatitis chronica atrophicans, lupus vulgaris, and lupus erythematosus. Surgery is also recommended in epidermoid carcinoma which arises in areas of scars from burns. These scars consist of fibrotic and relatively avascular tissue and the tumors arising in these areas are not radiosensitive. Some of these malignancies are recurrent and frequently the whole scar should be removed.

We share the experience of others in that radium has no advantage over roentgen-ray therapy in skin carcinomas. Radium is more convenient and for this reason more efficacious when the disease is located in inaccessible locations, such as the external auditory meatus or when the nasal mucosa is involved.

In the great majority of our cases we preferred to use some surgical procedure or electrodesiccation with curettage. This was followed by roentgen-ray irradiation and in a few selected cases by radium irradiation. With this combination of methods we believe we obtained a high percentage of cures and also good cosmetic results. The amount of irradiation used postoperatively was smaller than if used alone, and therefore we have seen no ill effects from a subsequent radiodermatitis.

Roentgen-ray treatment of skin cancers differs with each therapist. Some physicians



1a

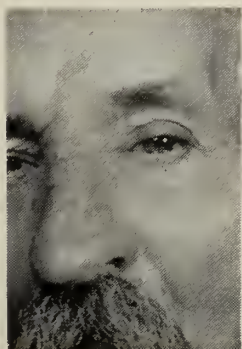


1b

Basal-cell carcinoma. Early diagnosis and early treatment give the best cosmetic results.



2a



2b

Infiltrating basal-cell carcinoma treated with electrodesiccation, curettage and roentgen-rays.

use soft rays; others, highly filtered rays. The kilovoltage and milliamperage varies considerably as well as the apparatus used. In our practice we use a broad focus Coolidge tube at from 90 to 120 KV, 6 MA and an 8 inch distance.

The usual dosage of roentgen-rays in treating skin cancers varies from 2000 to 5000 r units of unfiltered roentgen-rays in the basal-cell carcinomas, and 3000 to 9000 r of filtered rays in the squamous-cell carcinomas. It has been our practice to use 1200 r to 3400 r of unfiltered roentgen-rays in the basal-cell carcinomas and 2400 to 5000 r in the squamous-cell carcinomas. Our treatments were given postoperatively. The amount of irradiation depends on each individual case. The grade of malignancy, location, size of the lesion, extent of invasion, whether local or distant. The disadvantage of roentgen-rays is a second degree roentgen reaction which, however, dis-

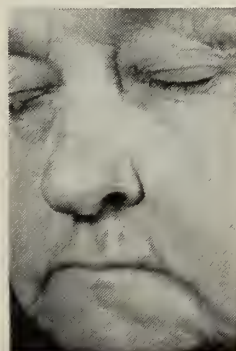
appears within a few weeks. The lesions heal quicker than if roentgen-rays alone were used. The total amount of radiation to be used may be given in one exposure, but this method increases the reaction without improving the result. Most of our patients received three divided exposures two or three days apart, thus dividing the total amount given.

It is commonly believed that cartilage is easily destroyed by radiation. Our experience has been the same as that of other workers.² Normal cartilage can withstand doses that are lethal to carcinomas. If, however, the carcinoma has ulcerated and infiltrated the cartilage, roentgen-rays were not used. Surgery was advised.

Carcinomas of the lip are squamous in nature. The dermatologist usually sees the earlier cases and before metastases have

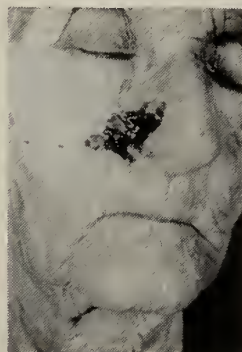


3a

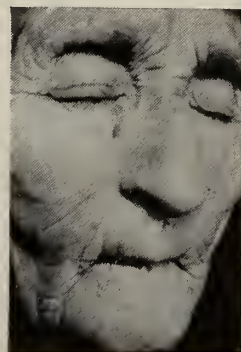


3b

Rodent ulcer treated with combination of electrodesiccation, curettage and roentgen-rays. No recurrence in three years.



4a

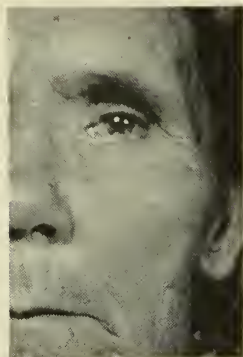


4b

Ulcerating basal-cell carcinoma treated with electrodesiccation and roentgen-rays.



5a

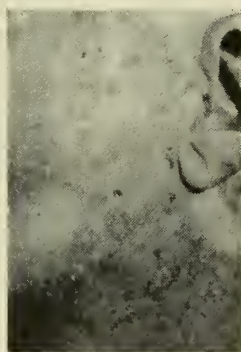


5b

Ulcerated basal-cell carcinoma of the inner canthus. Was treated with dessication and curettage, and 2800 r of unfiltered roentgen-rays were given postoperatively.



6a



6b

Squamous-cell carcinoma which was preceded by senile keratosis. The numerous keratoses of the so-called "farmer's skin" can be seen.

occurred. These cases usually are satisfactorily treated with cautery and roentgen-rays. Extensive cases, we believe, should be treated surgically. It is our belief that prophylactic dissection of regional lymph glands is rarely necessary and may prove harmful by diverting the lymphatic flow to inaccessible nodes. Furthermore, a considerable proportion of palpable nodes prove to have been enlarged by inflammation and recede when the primary lesion has been eradicated. It is unnecessary to treat the drainage area.³ In cases where metastases have already occurred, surgery, heavy roentgen, or small platinum radium needle therapy is recommended. In early metastasis, a block dissection is suggested. If the glands are matted or ruptured masses are

present palliative roentgen-therapy is recommended, which even in this stage may be curative.

Prognosis

Few conditions in medicine offer a higher percentage of cures if the method of treatment in each individual growth is carefully selected. The prognosis depends on early recognition of the lesion and proper treatment. If metastasis has occurred in the squamous carcinoma, the prognosis is poor but not hopeless.

During the past few years we have treated over 400 patients with skin cancer. Thirty-four patients returned for at least one yearly check-up; 125 patients returned at two-year intervals; 98 patients returned at three-year intervals, and 47 patients returned after three yearly visits for routine observation.



7a

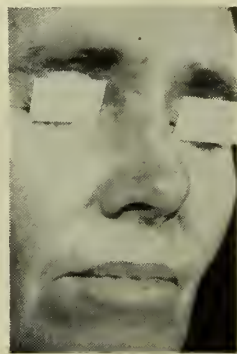


7b

Squamous-cell carcinoma of the lip. No recurrence after three years. A combination of electrodessication and roentgen-ray treatments were used.



8a



8b

Squamous-cell carcinoma treated with electrodessication, curettage and roentgen-rays. No metastasis or recurrence after three years.

TABLE 1

LOCATIONS OF BASAL-CELL CARCINOMA
IN 196 PRIVATE CASES

Cheeks	45
Nose	44
Canthus and eyelids.....	41
Temple	20
Forehead	17
Ears	14
Neck	5
Chin	5
Other parts	5
Total.....	196

TABLE 2

LOCATIONS OF SQUAMOUS-CELL CARCINOMA
IN 91 PRIVATE CASES

Lip	23
Hands	18
Cheek	14
Temple	7
Ear	7
Forehead	6
Nose	4
Canthus	4
Scalp	1
Other parts	7
Total.....	91

This gave us a total of 304 patients whom we have followed. From these we have drawn our conclusions and statistics. Of these 304 patients, 91 had squamous-cell carcinoma (30 per cent) and 213 had basal-celled carcinoma (70 per cent). Only early cases of squamous-cell carcinoma were treated. Carcinomas that had metastasized were not treated in our office. Four patients with squamous carcinoma developed metastasis after the primary lesion was treated. Seventeen patients had a recurrence (77 per cent cures). The majority of these recurrences were present on the lips and were either treated again or referred for surgical removal. Two cases that returned with recurrences of several months duration had metastases. Seven of the early recurrences that were treated again seemed to have been cured (84.6 per cent). Eight patients were lost from observation. Seventeen of the 213 patients with basal-cell carcinoma were classified as having multiple lesions, two or more lesions being present

at the same time; 196 patients had only one lesion present when first seen. There were five recurrences after treatment, which would indicate 97.7 per cent cures; 28 of these patients developed one or more new lesions during the period of observation.

The ratio as to sex was 163 males and 141 females. The most frequent locations are shown in tables 1 and 2.

Summary

1. Three hundred and four patients with skin cancer have been treated and observed for one or more years.
2. Ninety-seven and seven-tenths per cent cures were obtained in the basal-cell carcinoma and 84.6 per cent cures in the squamous carcinoma.
3. We prefer a combination of methods of treating skin cancer. It gives a high percentage of cures.

REFERENCES

1. Finnerud, Clark W.: Metastatic Carcinoma from the Skin, J.A.M.A. 82: 775 (March) 1924.
2. Driver, James R., and Cole, Harold N.: Treatment of Epithelioma of the Skin of the Ear, Am. J. Roentgenol. 48: 66 (July) 1942.
3. Hall, W. C.: Am. J. Roentgenol. 48: 116 (July) 1937.

DISCUSSION ON PAPER OF DR. WM. L. DOBES AND
DR. PHILIP NIPPERT

Dr. Lee Howard (Savannah): Dr. Dobes has presented a very comprehensive paper on this important subject, and considering cancer as a whole, if we include basal cell skin lesions, skin cancer is much the largest group. Skin cancer is also important in that the majority of cases are easily curable. My knowledge of the eradication and handling of skin cancer is largely statistical and histological, and Dr. Dobes has covered this subject so thoroughly that I will limit my discussion to a few cases and the importance of taking biopsies, when indicated or possible.

One naturally hesitates to remove a portion of a small lesion, as complete removal is preferable in most cases. For larger lesions, biopsy is definitely indicated in the majority of cases, dependent upon the location and method of choice for removal. There is no need for a preliminary biopsy when it is planned to excise the entire lesion except for purpose of diagnosis. This leaves a definite indication for biopsy of larger lesions that are to be removed by desiccation or irradiation. For many lesions wide removal with a sharp knife seems the best method from both a cosmetic and curative standpoint. Several cases, seen at the Savannah Cancer Clinic, with large, hornifying, epidermoid type lesions on the back of the hand, in the same age group, have been treated by either surgical excision or irradiation. One case well removed with x-ray developed axillary metastases within a year, while a similar case having surgical removal is well after three years. This is not conclusive but sug-

gestive, as the two lesions were almost identical in size, location, gross appearance, histology, and duration, and both patients appeared to be free from metastases before treatment.

The statistics now being compiled by Dr. W. J. Murphy for the twelve State-Aid Cancer Clinics, will, in time, give us a valuable cross-section of skin cancer in Georgia. Only cases that have been examined histologically can be classified in an already large list of reported cases through the clinics. Dr. Dobes, and other skin experts, can often readily make a diagnosis from the location and appearance of the lesion. However, for statistical purposes, it is only those cases accompanied by histological reports that we can turn to for any long standing information, as the classification of skin cancer is based entirely on cell type and arrangement.

Lieut. Philip H. Nippert, MC-V (S) USNR: Dr. Dobes deserves a great deal of credit for having been able to satisfactorily follow more than 75 per cent of our patients treated. I am sure those of you who have attempted a follow-up on any large group of patients will agree that this is very commendable. Cancer of the skin is one of the most satisfactory diseases to treat. A high percentage of cures can be obtained, the cosmetic results are good and the patients are well satisfied. Unfortunately this same rate of cure and number of satisfied patients does not obtain in all diseases of the skin.

As has already been said in regard to treatment, "That which completely eradicates the disease with the least amount of scarring is the treatment of choice."

Dr. Wm. L. Dobes (Atlanta): I should like to stress that we feel that only the earliest squamous-cell carcinomas fall into the realm of dermatology. We do not treat late and extensive cases or those that have metastasized. We try to take biopsies on all lesions suspicious of being squamous-cell carcinomas. We feel that the final success depends mainly upon two things: early diagnosis, and not necessarily the method used but the skill with which it is used.

1945 ANNUAL SESSION OF A.M.A. IS CANCELLED

"The Board of Trustees of the American Medical Association, after consideration of all factors involved," *The Journal* of the Association says in its January 20 issue, "has officially announced the cancelation of the Ninety-Fifth Annual Session of the Association scheduled for Philadelphia June 18-22. This is the fourth time in the Association's history and the second time during the present war that an annual session has not been held. In 1861 the annual session was postponed for a year because of the outbreak of the war between the states. In 1862 it was again postponed for a year. The 1943 annual session scheduled to have been held in San Francisco was canceled. Last year the session was held in Chicago. It is expected that a meeting of the House of Delegates will probably be held in 1945 in Chicago at a time to be announced later in *The Journal*. The action this year is taken voluntarily in order to cooperate to the fullest possible extent with the request of the Office of Defense Transportation and in the interest of the nation's war effort."

COMMON DUCT STONES

BEN H. CLIFTON, M.D.

Atlanta

Any study of surgical procedures on the common bile duct, for stones or otherwise, must of necessity take into consideration the biliary apparatus as a whole. Indeed the complete physical status of the patient must be studied and determined as far as is possible. Inflammatory conditions of the common duct, with or without stones, usually follow long standing biliary infection and the common duct involvement, with or without stones, is usually a later pathologic process. Infections usually begin in the wall of the gallbladder and following one exacerbation after another, the liver, the bile ducts, and the pancreas become involved through the lymphatics or by direct continuity of tissue. Early inflammatory lesions of the gallbladder with the infection extending down into the crypts or pockets predispose to the formation of stones in the gallbladder. No doubt, as the infection spreads, stones might form in the common duct. Whether the stones always form in the gallbladder and migrate to the common duct through the tortuous cystic duct is not likely. Probably that is the most frequent occurrence but unquestionably stones can and do form within the common duct. Pathologically, following in the wake of each inflammatory episode more damage is done. The inflammatory reaction produces fibrous tissue and the walls of the gallbladder become fibrous and lose their distensibility. These episodes of inflammation result in adhesions of a varying degree between the gallbladder, duodenum, stomach and colon and the liver usually becomes more involved. In the long standing cases the adhesions become so tough until it is with difficulty at times they are separated. Too often this is the local picture of disease seen when the patient comes to operation. Once the stones have formed, by mechanical irritation alone they increase the inflammatory reaction and may produce ul-

ceration and the formation of strictures and even complete obliteration of the common duct. In the long standing cases the duct is usually dilated and the walls thickened so that it is palpated readily. Frequently, with the index finger in the foramen of Winslow and by compression with thumb, one may outline a thickened duct and palpate stones within the duct. However, negative palpation does not necessarily mean that stones are not present. In the last 185 gallbladders operated upon by me (private cases) there have been 15 common duct stones. This gives an incidence of little over 8 per cent. This is rather low as compared with the common duct stone percentage in the literature, which varies from 7 to 20 per cent. The duct was opened in 8 other cases without finding stones. I am sure in some of these cases in which the duct was not opened stones were overlooked, as I have never been as bold about opening the common duct as many of the leaders of the profession.

The symptoms of the common duct stones are not so different from stones in the gallbladder. Most of the patients had repeated attacks of biliary colic over a considerable period of time. These attacks may or may not be followed by fever, by jaundice or by chills, but if such an attack is followed by either of these symptoms and signs it makes one strongly suspect a common duct stone. No doubt a good many common duct stone cases will show a slight transient jaundice, which goes undetected clinically, but often if patients are asked if their eyes looked like they were "bilious" following the attack they will frequently say "Yes, they turned yellow." Jaundice that follows attacks of "acute indigestion" and grows progressively more intense whether there is local tenderness or not over the gallbladder, is almost conclusive evidence of a common duct stone. This is almost certain to be true if the patient has had chills and fever. In a case in which a common duct stone is suspected in the absence of definite clinical jaundice, if the serum bilirubin test is made within twelve to twenty-four hours following the attack, frequently there will be an increase in the bilirubin in the blood but not high enough to be manifested clin-

ically. Occasionally duodenal drainage for suspected stones in the common duct, especially if the gallbladder has been previously removed, will show cholesterol crystals in the drainage which is strong evidence suggestive of stones. The fact that common duct stone is more common than we have heretofore thought, as the literature clearly proves, makes it necessary that the surgeon be prepared to investigate the common duct when any operation is done on the biliary tract.

Up to comparatively recent times the common duct was not opened except for very definite reasons, as the palpation of a stone in the duct or for long and persistent jaundice. Now due to the better understanding of the physiology of the gallbladder and the sphincter of Oddi, and the known fact that this mechanism is disturbed very frequently by inflammation or stone or both, has led to a more frequent investigation and exploration of the common duct. This can be done by competent hands with very little added danger to the patient. There are certain definite guides which will lead one to suspect stones in the common duct before and at operation. These are: (1) History of repeated gallbladder attacks especially if followed by jaundice. This is not 100 per cent true because one of my patients developed jaundice which was progressive following the first attack. (2) Small contracted gallbladder containing many small stones or even no stones. (3) Dilated common duct. (4) Stones actually felt in the common duct. (5) Muddy bile or flocculi within clear bile at operation when the common duct is aspirated, as it is always done before it is incised.

At operation it must be remembered that adequate exposure is essential. Adhesions must be separated with the utmost gentleness and strict attention paid to the prevention of loss of blood. If one has a rather liberal incision and places his hand gently above the liver and permits air to enter the space between the diaphragm and the liver, thereby eliminating the negative pressure, the liver can usually be pulled with ease downward and outward to a great degree. If this is done, and with proper retraction,

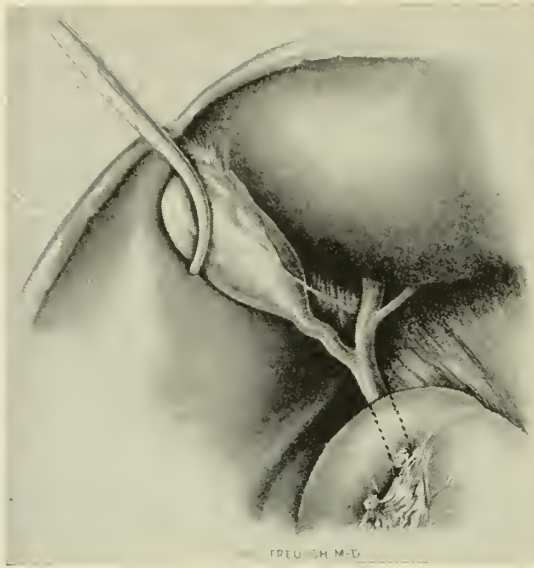


FIGURE 1

Relative position of cystic artery to the cystic duct and periduodenal adhesions, which are of sufficient size to ligate at times.

in the majority of cases the common duct area can be readily exposed. Even at the present time there are two schools of thought; one which believes the common duct must not be opened except for very definite reasons, and the other being that it should be opened when there is a reasonable suspicion of duct stones. My own belief is that if the gallbladder is to be removed and the common duct explored, it is best to open the common duct first and do the exploration and remove the gallbladder as the last procedure. By so doing the gallbladder can be used as a tractor. One should be thorough but gentle. After the duct is opened and stones are removed, the duct is flushed out with warm normal saline solution. The ampulla is then dilated up to a quarter of an inch, if possible. Frequently by packing a small strip of gauze gently in the common duct small stones adherent to the walls of the duct will be removed. Let me urge that care be exercised in passing a probe through the ampulla because of the ease with which the duodenum might be punctured. Occasionally one runs into difficulty which might jeopardize the patient's life if the operation is unduly prolonged. In such cases, once in a great while it is better to stop at one stage and be content with external biliary drainage and com-

plete the operation at a later time. It is more comforting to save a patient's life by doing two operations than losing the patient following one complete operation.

When the common duct is opened I think it should always be drained, preferably by a soft T tube, the arms of which have been cut off to about one-fourth inch, which facilitates the removal of the tube without damage to the duct. The duct should be closed snugly around the tube and several grams of sulfanilamide sprinkled within the abdomen around the common duct area. A small Penrose or cigarette drain, together with the tube, is brought out lateral to the incision through a stab wound. I think this most important; it adds very little to the length of the operative procedure, and since I have practiced this I have not had a single hernia develop. Drainage should be instituted in the average case ten days to three weeks. In a case of long standing jaundice, however, where the liver is enlarged and where the head of the pancreas is enlarged, it is my practice to drain the common duct from three to four months. After drainage has been instituted, for some time before the tube is finally removed, it should be clamped at intervals. This will give a good

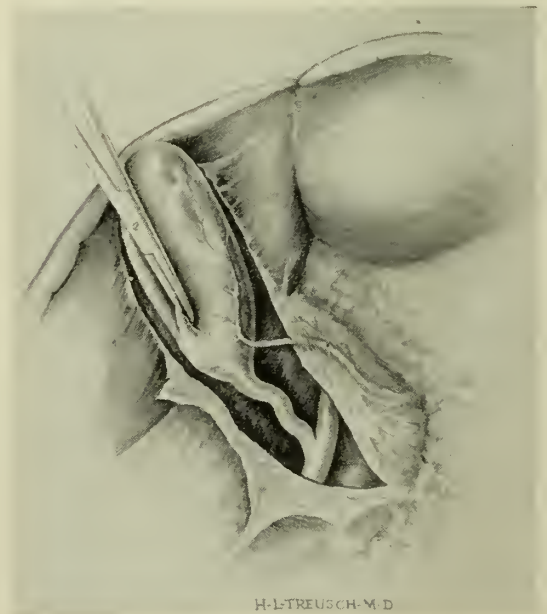


FIGURE 2

Shows the peritoneum open and the cystic artery and cystic duct clearly identified. This should always be done when possible so they may be ligated separately.

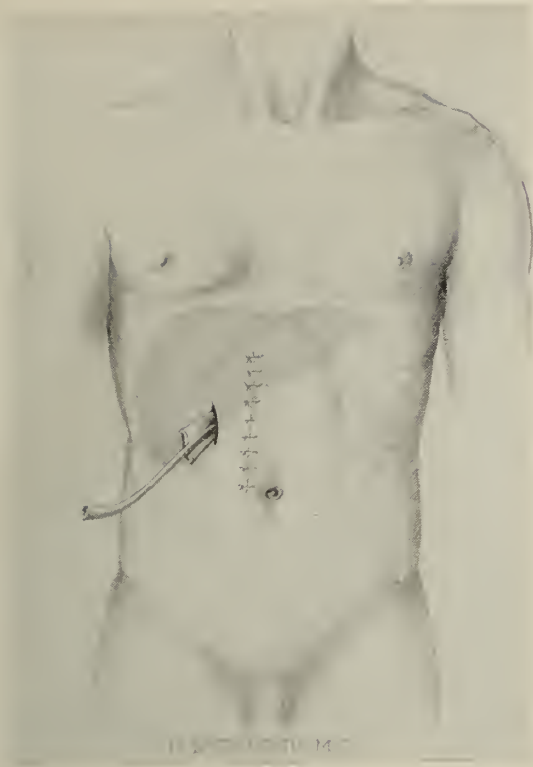


FIGURE 3

This shows the drains brought out through a stab wound, reducing the frequency of postoperative hernias.

idea as to whether the common duct is patent or not. If the patient experiences colic or any type of pain, this indicates that the common duct is at least partially obstructed and that the tube should not be removed.

More recently we have been doing cholangiograms. This is of decided help, especially in the cases in which common duct stones were suspected from the history but were not found upon exploration of the common duct. If an unfound stone or an overlooked stone is shown by the cholangiogram the method devised by Pribram should be tried (injection of ether into common duct and inhalation of amyl-nitrate). Sometimes this will cause fragmentation of stones so they will pass on into the duodenum. I think this is of decided help in the cases in which stones were suspected from the history and at operation were not found. If the cholangiogram shows a defect one must not be too eager to conclude that it is a stone as it might be due to an air bubble, to a blood clot or to a plug of mucus. Cholangiogram should be repeated with the patient's

position shifted and the pictures compared with previous ones. If the shadow is due to air, blood clot or mucus, frequently the second picture will prove it not to be a stone.

After all is said and done, the chief motive of common duct surgery is the removing of the stones or relieving the obstruction so there may be an uninterrupted flow of bile into the intestines.

I must stress the importance of cooperation between the internist, radiologist, and the clinical laboratory in the diagnosis and in the proper preoperative preparation of some of these patients for surgery. It is true that too often patients with long standing biliary infection, with or without stones, have myocardial damage, liver damage and general debilitation. Most patients that die following operations, especially those jaundiced, will die from hemorrhage or kidney insufficiency or myocardial failure, and it is in these extreme cases that proper preparation before operation is just as important as the preparation of the patient for operation upon the prostate gland. The type of anesthetic will depend upon the operator, the patient's condition and who is giving the anesthetic, more than the actual anesthetic agent itself.

There is another type of patient I should like to mention; that is, one who has gallstones, whether in the gallbladder or common duct, and who has cardiac symptoms. In certain cases the removal of the gallbladder or common duct disease relieves the cardiac condition. This relation is so common that one should be on the alert, otherwise some chronic suspected cardiac patient will be denied surgery they are entitled to, and which would relieve their cardiac symptoms. Another condition that is sometimes relieved following the removal of the gallbladder, or common duct disease, is diabetes. One of my cases fell into this group. In such cases probably the associated pancreatitis had interfered in some way with the formation of insulin.

BIBLIOGRAPHY

1. Pribram, B. O.: *New Methods in Gallstone Surgery*, Surg., Gynec. & Obst. 60: 55-64, 1935.
2. Clute, Howard M., and Lawrence, Knowles B.: *Cholangiographic Artefacts Resembling Common Duct Stones*, New England J. Med. 227: No. 20, (Nov. 12, 1942).

3. Ravdin, I. S., Royster, H. P., and Sanders, G. B.: Reflexes Originating in the Common Duct Giving Rise to Pain Simulating Angina Pectoris, *The American Surgical Association*, Cleveland, Ohio, (April 6-8) 1942.
4. Walters, Waltman, and Snell, Albert M.: *Diseases of the Gallbladder and Bile Ducts*, Philadelphia, W. B. Saunders Company, 1940.
5. Deaver, John B.: The Sequelae of Biliary Tract Infection, *J.A.M.A.* 95: 1641-1644. (Nov. 29) 1930.
6. Lahey, Frank H.: Common and Hepatic Duct Stones, *Am. J. Surg.* 40: 209-216 (April) 1938.
7. Mirizzi, P. L., F.A.C.S. (Hon.), Pablo L., Cordoba, Argentina, *Clinical Congress American Coll. Surg.*, Boston, Mass., (Nov. 3-7) 1941.

MULTIPLE ARTERIAL THROMBOSES INVOLVING THE MAJOR VESSELS OF THE LOWER EXTREMITIES AND THE RIGHT ARM

Report of Case

ARTHUR D. LITTLE, M.D.

Thomasville

GEORGE T. MCCUTCHEN, Major, M.C.,
Army of the United States

It is not our intention to discuss arterial thrombosis in any detail, for any one interested will find a rich literature on the subject; and anything we may say would have been much better said in the voluminous articles already written. Having nothing new or original to offer, we will confine our discussion to the reporting of an unusual case in which the large arteries supplying the lower extremities and the right arm were occluded by thrombi thrown off from a fibrillating heart. The fact that the patient survived three major surgical procedures in spite of her poor general condition is also of interest and may be attributed in great part to the use of refrigeration anesthesia.

Report of Case

Mrs. H. M. C., aged 55, was admitted to the John D. Archbold Memorial Hospital, Thomasville, Nov. 24, 1943, on the service of the late Dr. R. A. Hill.

Chief Complaint: Heart trouble, high blood pressure, extreme nervousness.

Family History: Mother died at 65 of cirrhosis of liver. Father died at 82 of heart trouble.

Marital History: Married 32 years; 8 children living and well. Youngest aged 11. Husband, aged 60, living and fairly well.

Menstrual History: Normal. Menopause at age 53.

Former Operations: Simple mastectomy for chronic coalescent mastitis (left) in 1933. Same breast lanced for abscess in 1916.

Had influenza complicated by a heart attack three

months prior to admission to hospital. Had been in bed under physician's care for three months and dyspnea had become so bad she was advised to enter the hospital under the care of Dr. Hill.

Progress Notes:

The following notes in connection with her physical examination were made November 25: Blood pressure 170/110. Heart beat irregular, and heart enlarged. Mitral insufficiency. Dyspnea on slightest exertion. Auricular fibrillation. Patient highly nervous and appears to be very ill.

November 27—Given digitalis grains 3 daily. Sedative at night. November 30—Doing nicely. Heart beats regular. Blood pressure 150/100. Much more comfortable. Dyspnea much better. December 2—Patient began to have pain in region of left knee about 4 A.M. Pain so severe had to be given an opiate for relief. At 9 A.M. pain in left leg continues. Left foot from ankle down seems bloodless and cold. At 11 A.M. left lower leg is cold and bluish, entire leg is cold and no pulsation can be felt below the inguinal ligament. A diagnosis of thrombosis of the left femoral artery was made and a surgeon was consulted with the view of doing an embolectomy. The surgeon thought the patient's general condition would not permit such operation. At 3 P.M. right hand is cold and no pulsations were felt below the axilla and no blood pressure reading could be obtained in right arm. At 6 P.M. left leg blue up to lower third of thigh. Pain practically gone from right hand and arm. Fingers of right hand are numb and cold but not discolored and show no signs of gangrene.

December 3—Left toes becoming gangrenous and left leg is discolored and cold to lower third of thigh. Very painful to touch above knee. Patient put on oscillating bed. At 3 P.M., right foot cold and big toe of right foot is discolored, which was interpreted as an occlusion of the vessels of the lower extremity.

We were called in consultation at this point and suggested that arteriograms of the vessels of right leg be made, with the hope of doing an embolectomy. An arteriogram was impossible on the left lower extremity because the pulse could be felt fairly well below the inguinal ligament. The arteriograms showed three points of blockage in the right leg. Embolectomy was thought to be inadvisable under the circumstances. The right hand and arm were improved, hand was less cold and there was no indication of gangrene in any of fingers, though all pulsations were still absent. Right and left femoral pulsations could now be felt, the left very indistinctly below the inguinal ligament. No pulsations below this point could be felt in either leg. The right arm is improving. The axillary pulse is palpable. The heart condition is worse; the sounds are distant and impulses weak. A general anesthetic is contraindicated.

At the suggestion of Major McCutchen both lower extremities were packed in ice.

December 4—Patient more comfortable. Right hand and arm less numb. Can move fingers and thumb without pain. Both legs discolored but gangrene is not advancing.

December 5—Dr. Hill thinks patient's general condition is showing improvement. Blood has been obtained

for transfusions but do not believe the load on the heart should be increased; 1000 cc. beclysyl 5 per cent given intravenously. Patient shows improvement as to general condition. Taking some food.

December 6—Patient stronger, in less pain but still in no condition for anesthetic. Temperature 100° F., this is an increase from 98.6° and we believe patient is getting some absorption.

December 7—We believed the patient had reached the maximum improvement which could be reasonably expected and we decided to amputate the left extremity the following day, under refrigeration anesthesia.

Two hours prior to operation a tourniquet was placed as close to groin as possible and ice firmly packed up to anterior superior iliac spine. One hour later the patient was given hypodermically an H.M.C. No. 2 with 1 150 gr. scopolamine.

Patient was placed on table, left leg was removed from ice, prepared for operation and amputated at mid-third of femur. Tourniquet was released but no bleeding took place and the soft tissues did not look too good. We used suction on femoral artery, milking it downward, but no clot or bleeding occurred. We then used a ureteral catheter to probe the vessel, up to the iliac bifurcation, but still got no bleeding. This made us believe that the site of amputation might not be high enough but we tied off the large vessels and closed the wound loosely, and placed a cigarette drain in wound. The patient made no complaint during the operation and there was no change in rate or quality of pulse.

The stump and right lower extremity were repacked in ice and the stump was dressed in seventy-two hours when we could see a definite line of demarkation, so we trimmed away considerable soft tissue and got slight bleeding. This was done daily until we got definite signs of viability; then the ice pack was gradually left off.

We continued to pack the right lower extremity in ice for another four days. At the end of this time her general condition was satisfactory and she was subjected to an amputation of the right leg.

The same preoperative orders were given and carried out and we amputated the right lower extremity at the middle third of the thigh and encountered some bleeding from the femoral artery and a few smaller vessels, but suction nor probing tended to increase bleeding. We closed the stump loosely with drainage. At the same time we did a more thorough debridement of the left stump but did not re-close wound as there was evidence of further devitalization and the femur was protruding from the wound.

We continued to dress and debride left stump. Ice was discontinued on the left stump but continued on the right. We dressed the right stump in ten days and much to our gratification the wound was clean and healing nicely.

By Jan. 7, 1944, the left stump looked well enough to re-amputate and the patient was so much improved that we believed she could take a light anesthetic of pentothal sodium, so under 0.5 gram, making a 2.5 per cent solution, we were able to thoroughly debride left stump, re-amputate the femur and close the wound loosely with drainage.

This wound healed as nicely as the right and the patient's general condition progressively improved. We were able to gradually omit opiates and sedatives. We began to let her prop up straight in bed on January 17. Ten days after the last operation she was placed in a rolling chair for one hour. She continued to sit up at longer intervals daily and later was allowed to go outdoors. The patient was happy, and although her heart was far from normal she was able to sleep and her appetite was fair.

Patient was too ill for some days following second operation to realize that her limbs had been amputated, but when she learned about it she was so happy to be alive and there was less shock and reaction than we feared. We believe she is fully resigned to her condition and duly appreciative of being alive.

A review of the literature fails to reveal a case in which the major vessels of three extremities suffered occlusion about the same time. It is also noteworthy that our patient survived the amputation of both lower extremities.

POLIOMYELITIS IN RUSSIA

Since the start of the war there have been few cases of polio in the Soviet Union, Dr. Sofia Markina, director of the Dzerzhinsky Children's Hospital in Moscow, told Leo Grulow, Russian War Relief representative, and Lillian Hellman, American author and playwright, who made a tour of this 400-bed hospital, outfitted with American blankets, sheets, pajamas and medical supplies sent by the relief agency.

The virtual disappearance of poliomyelitis among Russian children was attributed by Dr. Markina to the wide dispersal of these children during the evacuation which took place early in the war.

The relief representative, who cabled this information to the agency's headquarters in New York City, also reported a decline of rheumatic fever among children, a decrease which Dr. Markina feels is due to the lack of protein in Russia's wartime diet. This dietary insufficiency, Dr. Markina pointed out, has, however, created other serious nutritional cases requiring sanatorium treatment. Citing an absence of epidemics as a whole, she indicated as a special wartime problem the rise in malaria carried by children who returned from evacuation points in Central Asia.

The staff of the Dzerzhinsky Children's Hospital, under Dr. Markina's supervision, is now making a study of wartime effects on the health of children.

HANDBOOK FOR CLINICAL PSYCHOLOGISTS

A pamphlet entitled "Handbook for Clinical Psychologists" is being distributed by the Neuropsychiatry Consultants Division, Office of The Surgeon General, to all clinical psychologists in Army installations in this country and overseas. The 128-page booklet will serve as a source book of various types of tests which have been found to be of special value in the psychological examination of patients.

CLASS OF SERVICE

This is a full-rate Telegram or Cablegram unless its deferred character is indicated by a suitable symbol above or preceding the address.

WESTERN UNION

02 SYMBOLS

DL = Day Letter
NL = Night Letter
LC = Deferred Cable
NLT = Cable Night Letter
Ship Radiogram

The filing time shown in the date line on telegrams and day letters is STANDARD TIME at point of origin. Time of receipt is STANDARD TIME at point of destination.

.QA03

Q.WB300 DL COLLECT GOVT=WASHINGTON DC 12 716P

MEDICAL ASSOCIATION OF GEORGIA EDGAR D SHAWKS SECRETARY=

58 / 478 PEACHTREE ST IE ATLA=

YOUR APPLICATION FOR PERMIT TO HOLD CONFERENCE MACON MAY 8-11 HAS BEEN REVIEWED. COMMITTEE FEELS THAT CONFERENCE CAN REASONABLY BE DEFERRED UNTIL NECESSITY FOR RESTRICTION ENDS. PERMIT THEREFORE DENIED=

R H CLARE SECRETARY WAR COMMITTEE ON CONVENTIONS.

MAY 8-11.

THE PRESIDENT'S PAGE

ORGANIZED MEDICINE'S PLAN

One of the most important eras in all of the practice of medicine is upon us. The plans for hospital service and medical care to be made available to every citizen of the United States, as suggested by the Council on Medical Service and Public Relations of the American Medical Association, are epochal in their expansiveness and philanthropic purposes. I cannot too emphatically urge every doctor in Georgia to study these recommendations, give them publicity, and manifest a cordial attitude toward their prompt and complete adoption.

I shall quote briefly from the statement of Dr. John H. Fitzgibbon, chairman of this committee: "The objective of the medical profession of this country is the provision of good medical care to every person in the United States. The Council on Medical Service and Public Relations intends to promote this objective." Providing *good* medical care is not an easy problem, and the eradication of conditions contributing to poor health requires cooperation between the medical profession and other public-spirited persons.

"In providing good medical care to the entire nation three phases of the problem must be solved," said Dr. Fitzgibbon.

"1. Adequate trained professional personnel and facilities for providing preventive, diagnostic, and treatment services must be made available to all.

"2. Sound economic arrangements for financing these services and facilities must be set up; and

"3. Educational efforts will be required to inform the people of the value of good medical care in order to induce them to make intelligent use of the services and facilities available."

Members of the council believe that the platform of the American Medical Association contains the fundamental principles upon which a sound, progressive plan for providing *good* medical care to a nation may be established. Accomplishment of this objective will require the sincere cooperation of the medical profession, government, industry, labor and many other interested groups and individuals.

Solution of this problem does not and will not require compulsion. The medical profession is now and has been agreed for years upon definite principles of a constructive nature, which if accepted by others concerned in this matter will lead to a satisfactory solution of the problem upon a voluntary basis. It is one of the functions of the Council on Medical Service and Public Relations to make these principles and their implications known to the medical profession, interested citizens, and public servants.

Certainly voluntary methods of insurance, utilization of existing facilities as far as possible, preservation of private practice, expansion of public health services, aid to the indigent or impoverished communities, and the principle of local determination of need and local control of administration are basic principles of Americanism.

It is desirable and important that you read the full report of Dr. Fitzgibbon, as well as the statement from Dr. Louis H. Bauer, member of Board of Trustees of the American Medical Association and a member of Council on Medical Service and Public Relations. Both may be obtained from the American Medical Association, 535 North Dearborn St., Chicago.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

FEBRUARY, 1945

DON'T NEGLECT CANCER

"Never before have we been so aware of the life-saving power of scientific research," said Clarence C. Little, S.D., Managing Director of the American Cancer Society. He added: "Out of the laboratories and on the firing line where millions of our young men are risking their lives, have gone sulfa drugs, penicillin and dried blood plasma. From the past we can take the names of killers conquered by science: yellow fever, smallpox, diphtheria and typhoid."

"Today research against cancer stands on the threshold of new and great advances. It has already given us ways of producing and of controlling the production of the disease in laboratory animals. It has begun to give us knowledge of how cancer cells differ from normal cells."

"But cancer research needs financial support and more trained workers. It must be given the material aid and security to make it efficient and increasingly powerful."

"Never before have we understood so well how to organize for the detection of precancerous conditions or to identify cancer in its early and curable stages."

"Few as yet realize the nature of the emergency which cancer presents. There are 17,000,000 living Americans who will die of cancer unless something is done. There are at least 5,500,000 of them who can be saved from death from cancer by simple, direct means."

"You who read this are one of the 'means' by which these lives can be saved. Learn the danger signals that may mean cancer and the ways in which the risk of cancer may be decreased. Pass this information on to others. Enlist during April in the Field Army of the American Cancer Society. If one of the danger signals appears either in your own life or in that of a friend insist on prompt fearless action. Go to your doctor for examination and advice."

"Education alone can save millions of lives even if research does not advance. No one can afford to be too busy to neglect this challenge. It is a choice between intelligent protection of yourself and those you love on the one hand, and ignorant risk of health, happiness and perhaps life itself, on the other."

"The American Cancer Society has been for over thirty years the one great national organization devoted to study and development of plans for cancer control. It stands firmly on three fronts where it is face-to-face with the enemy; research, service, education. It is going forward in support of all of these fields. It is going to take with it millions of Americans, who realize the great need and their power to help."

"The American Cancer Society may have a division of its field army near where you live. If so go to it for free information. If it is difficult or impossible to reach a local division, write direct to the American Cancer Society, Empire State Building, New York 1, N. Y."

BIRTHS AND DEATHS IN 1944

Births in the United States continued at a high level in 1944, although there was a recession from the two preceding years. The total number of births in 1944 will be somewhat less than 3,000,000, or about 6 per cent below the figure for 1943, which established a high record for births; it is also slightly below the 1942 figure. However, births in 1944 are well above prewar figures and, in fact, their number still exceeds any year in American history prior to 1942.

The estimate of births for 1944 is based upon country-wide records of the Census Bureau for the first 10 months of the year, and on trends for areas for which later information is available. It includes an allowance for underregistration. The total number corresponds to a birth rate of about 22.5 per 1,000 resident population, which excludes overseas military personnel and civilians. The year 1944 marks the third in succession in which the birth rate has exceeded 20 per 1,000.

The decline in births last year was almost country-wide, the only notable exceptions being those areas which have continued to attract population because of their war industries or near-by military installations. Typical of such areas are the Pacific Coast and Rocky Mountain States, where the births remained close to the record level of 1943, or even exceeded it.

Along with the continued high level of the birth rate, the infant mortality record has been exceptionally favorable despite war conditions. Everything points to a new low level in the death rate among babies. The figure for the year is estimated at 39 per 1,000 live births. This compares with a final figure of 40.4 per 1,000 in 1942 and 1943. The infant mortality rate for 1944 is no less than 14 per cent below that for the last prewar year, 1941.

The general death rate in the United States in 1944 is estimated at 10.7 per 1,000, or about 2 per cent lower than in 1943. The year's mortality must be regarded as exceptionally favorable inasmuch as it is based on the resident population, which excludes the millions of selected healthy young men in our armed forces overseas. Actually, if allowance were made for this, the resident death rate would be at or near an all-time minimum. The 1944 mortality record is all the more remarkable as the year began in the midst of an influenza epidemic. For much the greater part of the year, the monthly death rates in 1944 have been below those of 1943.

The natural increase of our population in 1944 will be in the neighborhood of 1,400,000 persons. This figure is based on our entire population, including the men overseas. It also takes into account all deaths among the men overseas, whether or not suffered in combat. The increase in numbers for 1944 is smaller than in the two years preceding. Even so, the rate of natural increase has for the third year in succession reached or exceeded 1 per cent; this may be compared with a rate of only 0.7 per cent during the prewar decade. The high rate of increase in wartime is necessarily only a temporary phenomenon, but it is remarkable that the rate has held at so high a level for as long as three years. A sharp reduction in the margin of births over deaths must be expected in the near future, when the absence of so many young men abroad exercises its full effect on the birth rate, while the death rate is subject to the contingencies of war. So far, the people of the United States have had the good fortune to escape any serious epidemic situation during the war, but obviously there is no assurance that this favorable condition will persist.—*The Bulletin*, Metropolitan Life Insurance Co., December 1944.

MEET MR. DINGELL

Meet Mr. Dingell, congressman from Michigan, one of the authors of the Wagner-Murray-Dingell bill in the 78th Congress of the United States.

The Wagner-Murray-Dingell bill died with the ending of the 78th Congress, but when the first session of the 79th Congress assembled, early in January 1945, Mr. Dingell was ready with a new

bill, a bill consisting of 90 printed pages and a bill too cumbersome to print in full in this Journal.

The bill (H.R. 395) is entitled "A bill to provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified Social Insurance System; to extend the coverage; and to protect and extend the social-security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several states to make more adequate provision for the needy aged, the blind, dependent children, and other needy persons; to enable the States to establish and maintain a comprehensive public assistance program; and to amend the Internal Revenue Code."

Without discussing the merits or deficiencies of this bill, each Georgia physician will do well to write his congressman for a copy of the bill and when it is received to give careful study to all pages of the bill. Let it be said here that Mr. Dingell has not changed much the original proposal in the 78th Congress.

ANNUAL SESSION OF THE ASSOCIATION CANCELLED

On page thirty-six of this JOURNAL is a message which is self explanatory.

Suffice it to say, this message is a reminder to all of us that our country is at war; and it should have some appeal to most of us to do our utmost — in any way possible — to end the present war.

We will miss the scientific and social programs of the annual session. They have become part of us. But the day will come when we can — in a peaceful world perhaps — meet again. In the meantime those of us who have been given the responsibility of carrying on the work of the Association invite the cooperation of each and every member.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

TWO COMMON INFANT FEEDING PROBLEMS

The solutions to some common infant feeding problems are often found to be surprisingly simple. In fact, the very simplicity of the solution may cause it to be overlooked in a search for a more complex answer to the difficulty.

During visits to Georgia physicians throughout the State, both in well child conferences and private offices, I have noted that two feeding problems seem most prevalent among the well babies examined. It is the purpose of this paper to discuss these two problems rather than to present any new data on infant feeding. The suggestions made are not new or original but they have been successfully used by me and may be a combination of methods used by other physicians.

Air Swallowing

Air swallowing occurs to some extent in all infants but most commonly causes trouble in artificially fed infants under five months.

The usual history given by the mother is that the baby takes a small amount of formula and then goes to sleep. He may or may not vomit. In thirty minutes to an hour he awakens crying hungrily for more. The baby is constipated, to which the mother ascribes his fretfulness. She may have given cathartics. Occasionally the mother says that the baby has colic.

Usually this is all the information that mothers supply and more than some offer. Many simply say that the infant wants to eat every thirty minutes to an hour. The physician can usually bring out the fact that the infant has been making a loud kissing noise when taking the bottle. He can also elicit the facts that the infant passes a lot of gas by rectum and that the stools are hard and dry. With this information he can build up the mechanical picture of the trouble.

The picture is this: the holes in the nipple of the bottle are too small. Practically all nipples are so manufactured because it is easier to enlarge the holes than to decrease their size. The mother may say that the holes are plenty large but lack of knowledge may disqualify her as a competent judge. Hold the bottle upside down. A few drops will run out quickly and then the flow will stop because no air is going back up into the bottle to replace the milk. Almost everyone has experienced difficulty in getting a soft drink out of a bottle when air has not been allowed to replace the liquid. If an adult has that much trouble with such a large opening, it is easy to imagine the infant's struggles with such a small one. Patented nipples which are constructed to allow air to flow into one hole as the milk flows out another are often at fault also, so do not be misguided by claims for this type.

The infant, in his efforts to obtain food, tugs harder and harder at the nipple, sucking in a great deal of air and very little milk. Part of the air which reaches the stomach stays there and a small part probably goes into the intestines. As the stomach fills with air, the infant's hunger pangs are satisfied. Tired out with his tussle with the nipple, he drops off to sleep. Soon the bubble of air in the stomach is expelled through the esophagus. If food is in front of the air it is pushed out, causing the vomiting referred to by the mother. Before long the baby is hungry again, begins to cry, is fed, and the whole process repeated.

Because of the small amount of food actually obtained, the baby soon becomes constipated. This condition, while causing the mother much anxiety, probably is of little importance per se to the physician. However, the secondary effects are important. The constipation indicates that the infant is not getting sufficient calories. The hard, dry stool interferes with the passage of gas so that the gas normally formed in the intestines tends to collect in the bowel and causes distention. This results in discomfort and the baby cries until the gas is finally expelled from the rectum and he is relieved.

When the condition has progressed this far, the mother has a cross, fretful infant. At one time the baby's crying is due to hunger, at another to bowel distention. If due to hunger, the infant will take the bottle; if due to distention, the baby may take the bottle for a tug or two, then push it away and continue to cry.

Changing formulas, substituting one brand of infant food for another, operating for pyloric stenosis or giving atropine for pylorospasm will not solve the physician's problem in this case. It is not the biochemistry of the food nor muscular obstruction but the simple mechanics of feeding that are at fault.

The most important step in correcting a faulty bottle nipple is to enlarge the holes — *really* enlarge them. Using a red hot needle has been recommended and is satisfactory if persisted in long enough. The trouble with this procedure is that the enlarging is done too cautiously. I have frequently taken a pair of surgical scissors and connected two of the holes in a three hole nipple. When the holes are large enough the air bubbles will pass up freely through the milk in the bottle every time the infant swallows. I have not yet strangled any babies although in several instances (one being my own baby) the milk ran so freely that a few drops ran down the infant's chin.

Other minor precautions that the physician should take in addition to enlarging the holes in

(Continued on page 45)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lillie W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 975 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACKson 7979.

"SHALL WE DRAFT NURSES?"

The Georgia State Nurses' Association announces the action taken by the American Nurses' Association at a special meeting of the Board of Directors and Advisory Council (with representation from 36 states) held Jan. 15, 1945, at the Henry Hudson Hotel, New York City, to consider the President's message to the Congress of Jan. 6, 1945, pertaining to the drafting of nurses for military service, the need for a National Service Act, and the implications and effects of a draft of nurses on civilian health.

It was voted by the board that in view of the emergency declared by the President, the American Nurses' Association endorse the principle of a draft of nurses as the first step to selective service for all women. The board also endorsed the enactment of a National Service Act as recommended by the President to the Congress. The board went on record as offering its services to Representative May, chairman of the House Military Affairs Committee, in the drafting of effective legislation. The board voted to do everything in its power to continue to accelerate the prompt voluntary recruitment of nurses to meet the present emergency. The Advisory Council endorsed this action unanimously. Miss Julia Miller, member of the Executive Board of Georgia State Nurses' Association and President of the Georgia League of Nursing Education, represented the Georgia nurses at the above meeting because of the illness of the President, Miss Lillian O. Nelson, who was unable to attend.

The following statement was released by the American Nurses' Association, quoting Katherine J. Densford, president:

"President Roosevelt's message to the Congress has clarified many issues for all citizens. I represent over 178,000 registered professional nurses. The association will give whole-hearted support to the President's proposal for a National Service Act, because it provides for a fair distribution of the burdens which must be borne.

"Our civilian hospitals have been caring for unprecedented numbers of patients since the war began. Although confronted daily with the needs of these patients, 75,000 registered nurses have volunteered for military service. Not all have

met the physical and other requirements of the Nurse Corps of the Army and Navy. Of the 58,977 nurses admitted to these two services, over 10,000 have been released for physical and matrimonial reasons."

Following is a copy of H.R. 1284. *An Act To Insure Adequate Medical Care For the Armed Forces*:

1. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled that Congress hereby declares that to provide adequate medical care for the armed forces of the United States it is imperative to secure immediately the services of additional trained and skilled women nurses.

2. Every woman residing in the United States who, on or after the effective date of this act, shall have reached the eighteenth anniversary of her birth but shall not have passed the forty-fifth anniversary of her birth and who shall have been or have become registered for and admitted to the practice of nursing by any state, territory, or possessions of the United States or by the District of Columbia is here made subject to registration and selection for and induction into land and naval forces of the United States under the Selective Training and Service Act of 1940 as amended. Such registration, selection, and induction shall proceed in accordance with the same procedure and be subject to the same exemption rights and obligations provided for male registrants by said act and regulations thereunder.

3. Any such registrant inducted into the land or naval forces shall be assigned only to medical duties in which her professional skill and training will be used in accordance with military requirements.

4. The President is hereby authorized and directed to prescribe such regulations as may be necessary to carry out the provisions of this act.

5. This act shall not affect the voluntary recruitment of qualified women for the Army or Navy Nurse Corps or the appointment of members to such Corps as officers in the Army or Navy as now provided by law.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

Mrs. C. B. Almand, of Winder, State Chairman of Doctors' Day, urges each auxiliary to observe Doctors' Day on March 30. Mrs. Almand first originated Doctors' Day and it was observed by her auxiliary, Barrow County, in 1933. In 1934 the Woman's Auxiliary to the Medical Association of Georgia adopted the following resolution:

"Whereas, the Auxiliary to the Medical Association of Georgia wishes to pay lasting tribute to her doctors. Therefore be it resolved by the Auxiliary to the Medical Association of Georgia that March 30th, the day that famous Georgian, Dr. Crawford W. Long, first used ether anesthesia, be adopted as Doctors' Day. Its object to be the well being and honor of the profession, its observance demanding some act of kindness, gift or tribute, in remembrance of her doctors."

Mrs. Almand further says "The Medical Association is a band of God's most noble men who give freely of themselves to those who need them — 'greater love hath no man than that he lay down his life for his fellowman.' Kings and warriors have changed our destinies but the medical profession and its protection has shaped and changed civilization. Remove it today and we are at the mercy of pestilences which destroyed other generations. So let us not forget in our busy wartime program, that our doctors need encouragement. They need boosting every day."

As the day calls for some act of kindness, Mrs. Almand has set forth seven suggestions:

1. Send telegrams, letters, notes or telephone each doctor in your town and county best wishes.
2. Publish a tribute to our doctors in your local newspapers.
3. Send news, cheerful letters to doctors who are in service.
4. Send flowers to doctors' homes, offices, hospitals, and place flowers on deceased doctors' graves in your cemetery.
5. Have a carnation boutonniere sent to each doctor in your town and county.
6. Plan social functions for your medical society.
7. Devote the day of March 30, 1945, to your doctor and our doctors.

Mrs. Kenneth McCullough and Mrs. Ben Minchew were hostesses to the Auxiliary to the Ware County Medical Society in January. Mrs. W. M. Flanagan, president, presided over an interesting business meeting that included a resume of the

fall and winter activities and plans for the new year. Mrs. McCullough, public relations chairman, announced that a committee composed of Mrs. Louis Pomeroy, Mrs. A. W. DeLoach and Mrs. Lovick Pierce had weighed and measured all the children at Isabella Street School. Mrs. B. H. Minchew, Red Cross chairman, announced that the members had been active in Red Cross work. Mrs. J. E. Penland and Mrs. McCullough helped to wrap and distribute 145 packages to the base hospital. The treasurer announced that the auxiliary has purchased one bond and will soon be able to purchase a \$100.00 one from the monthly stamps bought by the hostesses. Fifteen members attended the meeting.

The auxiliary to the Georgia Medical Society met at the home of Mrs. G. H. Lang in Savannah recently, with the president, Mrs. S. Elliott Wilson, presiding. A letter was read from Mrs. H. G. Banister thanking the auxiliary for a donation of \$50.00 to the student loan fund.

Mrs. John Elliott, chairman of Public Relations War Participation and Legislation, reported that a committee composed of Mesdames L. W. Williams, S. Elliott Wilson, Henry Frech, R. L. Neville, W. R. Dancy, Hugo Johnson, Jr., Sam Rosen, R. E. Graham, G. H. Johnson, Sr., Tayloe Compton and Mrs. Henry Levington had participated in the street sale of tuberculosis bangles and Christmas seals. Reports were given by Mrs. W. R. Dancy, Hygeia chairman; Mrs. Charles Usher, chairman of Yearbook; Mrs. R. E. Graham, corresponding secretary; Mrs. Sam Rosen, chairman of Doctors' Day; Mrs. S. Elliott Wilson, chairman of War Participation, and Mrs. Lester Neville, Scrapbook chairman.

The meeting was then turned over to Mrs. H. M. Kandel, chairman of programs, who introduced Miss Anne Taylor and Mrs. Charles D. Center of the State Department of Public Health. Mrs. Center gave a talk on "What Kind of Sex Education?" The next meeting to be held at the home of Mrs. E. C. Demmond.

The Randolph-Terrell Medical Auxiliary held a recent meeting at the home of Mrs. W. G. Elliott in Cuthbert. The meeting was called to order by Vice-President Mrs. T. F. Harper in the absence of President Mrs. Leonard Rush Massengale. The program chairman, Mrs. Harper, read an instructive pamphlet on socialized

medicine. Donation to student loan fund was discussed.

The Woman's Auxiliary to the Fulton County Medical Society has sponsored five educational programs this year. As the main objective of the auxiliary includes all phases of health, one of the outstanding programs was the annual health education meeting in October. The president, Mrs. John W. Turner, invited all parent-teacher presidents and health chairmen, principals, health and home economics teachers of all elementary and high schools in the Fifth District and presidents of the Federated Women's Clubs. Dr. Ullin Whitney Leavell, national educator, director of child study clinic, Peabody College, Nashville, Tenn., was the speaker. His subject was "Diagnostic and Remedial Techniques in the Child's Development and Education."

He classified children in every classroom into four distinct groups from the standpoint of reading ability:

1. Children of superior ability.
2. Children of normal ability.
3. Slow learning children.
4. Children with normal or superior native abilities but who are retarded in reading power.

Dr. Leavell said "Our American philosophy as applied to education demands special consideration for every child in each of the four groups. It is, therefore, the responsibility of the school to make a professional and critically diagnostic study of failing children. The public school program of the very near future will include a center for critical diagnostic and remedial work, and thus the child shall receive the necessary stimulation and guidance for the development of skills in reading and other abilities necessary for the efficient citizenship in American democracy."

PROGRESS IN PROGRAM FOR MEDICAL HISTORY

According to a report from Colonel Albert G. Love, historian of the Army Medical Department, plans have been made to complete the medical history of World War II six months after victory in the Pacific. Several officers are now assigned to the historical program, approximately half of them serving in overseas theaters. Most of these officers hold graduate degrees in history from leading universities throughout the country. They were commissioned in the Medical Administrative Corps following completion of training in Officer Candidate Schools. These officers are working on the administrative aspects of the medical service including supply, personnel, training, and hospital construction. The professional medical experience of the Army will be recorded by medical officers especially qualified in various specialties.

By means of this well-manned staff, the history of the Medical Department in the current conflict should be completed within the time limit set by Colonel Love. Previous histories published by the Medical Department appeared several years after the cessation of hostilities.

Twenty-three years were required to complete the medical history of the Civil War; ten years to complete that of the first World War. Early publication of the current history will be advantageous in that many of the administrative and scientific advances in military medicine will be applicable in planning for national defense and civilian practice. Thus the things which the Army is learning today on the world's battlefronts—improved methods of collection and evacuation of the wounded with prompt treatment, better medical and surgical care, the use of new drugs and appliances, control of communicable diseases, advances in reconditioning—are destined to reach the public domain while the knowledge acquired by the Army is still fresh.

At a meeting of historical officers held in the Office of The Surgeon General on December 6, announcement was made that sufficient volumes would be published to cover the entire scope of the Medical Department's professional and administrative work. Material for the series of volumes is rapidly accumulating from installations in this country and overseas. Colonel George R. Callender, Director of the Army Medical School, stated that excellent reports on missile casualties have been received for the volume on wound ballistics covering several campaigns.

The series of volumes gives promise of being the most complete and revealing chronicle of military medical advances ever compiled. The Surgeon General and other authorities in the War Department are lending full support to the historical project.

MEDICAL AND SURGICAL RELIEF

Mr. Arthur Kunzinger, treasurer of the Medical and Surgical Relief Committee, has announced that for the six month period ending Dec. 31, 1944, the Committee's donations to 21 countries including the United States, amounted to \$43,669.87.

The territory covered by the Medical and Surgical Relief Committee has increased as the number of liberated countries has increased, and contributions now reach France and Italy. United States tops the list of beneficiaries with \$16,386.48 worth of medical, surgical and dental supplies of which the U. S. Navy got \$3,542.13, the U. S. Army \$1,025.40, and various civilian hospitals and welfare agencies the balance of \$11,818.95. The greatest number of shipments for this period went to China and India, while the most valuable single contribution amounting to \$4,951.76 went to L'Entre Aide Francaise for the relief of French children.

The Medical and Surgical Relief Committee is distinguished by its adherence to two principals: 1. No authentic appeal is ever turned down, and 2. medical aid is the only form in which aid is given. Contributions of medical, surgical and dental supplies and instruments will soon reach the \$700,000 mark. The exact figure to date is \$690,715.60.

NEWS ITEMS

Members of the profession were invited to attend the Southern Regional Conference of the Council on Medical Service and Public Relations of the American Medical Association, Academy of Medicine, 875 West Peachtree

Street, N.E., Atlanta, Friday, Feb. 23, 1945. Luncheon was served at the Biltmore Hotel.

Dr. M. Noel Stow announces the opening of his office for the practice of ophthalmology, Parkwood Medical Building, 1746 K Street, N.W., Washington, D. C.

Dr. B. L. Shackelford was elected president of the Georgia Baptist Hospital staff; Dr. Claude Griffin, first vice-president; and Dr. L. H. Muse, secretary, at the annual meeting held recently.

The Georgia Medical Society recently held its meeting at the society's hall, 612 Drayton Street, Savannah. Papers: "Advances in the Rapid Treatment of Syphilis," Dr. Clarence A. Smith, U.S.P.H.S., Oatland Island; "Fever Therapy and Penicillin," Dr. W. J. Clough, U.S. P.H.S., Oatland Island. Members of the Armed Forces were especially invited.

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, Jan. 16, 1945. Dr. J. D. Applewhite was in charge of the program.

Dr. Edgar H. Greene, Dr. W. A. Selman, Dr. H. P. McDonald and Dr. Edgar D. Shanks, Atlanta, were guests of the Meriwether County Medical Society recently. Dr. R. B. Gilbert, secretary, was host at a bird supper. Dr. Greene read a paper on "Menstrual Disorders"; Dr. McDonald discussed "Kidney Diseases." The following officers were elected: President, Dr. R. L. Bennett, Warm Springs; vice-president; Dr. V. H. Bennett, Gay; secretary-treasurer, Dr. R. B. Gilbert, Greenville; delegate, Dr. Charles E. Irwin, Warm Springs; alternate delegate, Dr. R. B. Gilbert, Greenville.

The Fulton County Medical Society held its Fortieth Anniversary Meeting and Banquet at the Biltmore Hotel, Atlanta, January 4. The program was: Call to order by the President; Installation of Officers; Announcement of Committees; Inaugural Address by the President; Miscellaneous Business; and Adjournment. Officers 1945: President, Dr. Joseph C. Massee; President-Elect, Dr. Thos. P. Goodwyn; Vice-President, Dr. Joseph C. Read; Secretary-Treasurer, Dr. McClaren Johnson. Board of Trustees: Dr. A. J. Ayers, chairman; Dr. B. H. Boyd, Dr. Don Cathcart, Dr. Ben H. Clifton, Dr. Thos. P. Goodwyn, Dr. McClaren Johnson, Dr. Joseph C. Massee, Dr. Wm. Perrin Nicholson, Dr. Joseph C. Read. Judicial Council: Dr. Calvin B. Stewart, chairman; Dr. Chas. H. Daniel, Dr. J. Elliott Scarborough. Committee on the Dr. L. C. Fischer Awards: Dr. Allen H. Bunce, chairman; Dr. Frank K. Boland and Dr. F. Phinizy Calhoun.

Dr. Bomar A. Olds announces the new location of his Atlanta office at 26 Linden Avenue, N.E., Atlanta, directly across from the Crawford W. Long Memorial Hospital.

Dr. W. H. Wall, Blakely, has moved his office and clinic to the Wade House on Bainbridge Street, next door to the post office.

Dr. C. E. Irwin, chief surgeon of the Georgia Warm Springs Foundation since November, 1936, will assume duties as head of the combined Columbus-Macon district

of the state and federal Crippled Children's Bureau. Dr. Irwin has been directing orthopedic work with the Crippled Children's Bureau in Macon for several years and will combine his district there with this unit, making a total of approximately 50 counties from the Columbus office.

Dr. Murdock Euen, Atlanta, was guest of the Southern Section of the American Laryngological-Rhinological-Otological Society in Charlotte, N. C., and read a paper on "The Value of the Magnet in Esophageal Structure."

Dr. Marion C. Pruitt, Atlanta, spoke before the Greenville County Medical Society, Greenville, S. C., February 5 on "The Do's and Don'ts in Decreasing Pain in Ano-Rectal Surgery."

OBITUARY

Dr. James Bell Carothers, aged 56, leading Atlanta physician, died Jan. 17, 1945. He was born in West Point, Miss. Dr. Carothers was graduated in the class of 1915 from the Emory University School of Medicine, Atlanta. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the Covenant Presbyterian Church. He is survived by his wife, Mrs. James Bell Carothers; a daughter, Mrs. L. S. Reteneller, Macon; his mother, Mrs. Nellie L. Carothers, West Point, Miss.; a brother; and three sisters. Funeral services were held at the Peachtree Chapel, with Dr. Herman L. Turner officiating. Interment in the Decatur Cemetery.

Dr. Elmer F. Fuqua, aged 65, Atlanta physician, died Jan. 6, 1945. He was born in Grand River, Iowa. Dr. Fuqua was graduated in the class of 1903 from the Central Medical College of St. Joseph, Mo., and in 1915 from the Missouri Medical College of St. Louis, Mo. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, a Mason, and a member of Grace Methodist Church. He is survived by his wife, Mrs. Elmer F. Fuqua; two daughters, Misses Fern and Vera Fuqua of Atlanta. Funeral services were held at the North Atlanta Baptist Church, with the Rev. C. C. Buckalow officiating. Interment in Crest Lawn Cemetery.

Dr. Walter Charles Tipton, aged 62, died suddenly at his home in Sylvester, Dec. 12, 1944. He was born in Isabella and was graduated from the University of Georgia School of Medicine, Augusta, in 1908. Dr. Tipton was a leading figure in civic affairs of Sylvester. At the time of his death he was chairman of the City Board of Education. He was a member of the Worth County Medical Society, the Medical Association of Georgia, the Sylvester Baptist Church, and a Mason. He is survived by his wife, Mrs. Vada Godwin Tipton, Sylvester; two daughters, Mrs. Morris King, Killeen, Texas; Mrs. James Sandifer, Locust Grove; and a son, W. C. Tipton, Jr., in the U. S. Navy. Also surviving are two sisters and two brothers. Funeral services were held at the Sylvester Baptist Church with Dr. C. M. Savage officiating, and interment in Hillcrest Cemetery.

TWO COMMON INFANT FEEDING PROBLEMS

(Continued from page 40)

the nipples are: (1) Be certain that the mother bubbles the baby once or twice during the feeding and at the end of the feeding; (2) ascertain that the mother is giving the boiled water between feedings or at least 10 minutes before feeding; (3) increase the amount of formula if the infant requires more; and (4) when constipation persists, increase the caloric intake by increasing the proportion of carbohydrates or milk.

In most cases the physician will be agreeably surprised at the increased amount of the infant's food intake and the ease with which the child will adjust himself to a regular feeding schedule with a 3 to 4 hour interval.

Occasionally a similar condition is found in a breast fed infant. There may be two or three reasons: (1) The infant is not held in the right position to grasp the nipple correctly or the nipple is deformed and the infant swallows air; (2) the infant is not getting enough milk from the breast and, after emptying the breast, continues to nurse so that he swallows air; and (3) the infant is weak and for some reason the milk does not flow easily. In this latter condition, milk must be expressed manually and fed to the infant by bottle.

As the infant becomes older and stronger, the complications of air swallowing rarely occur because he is taking many other foods. He is either drinking from a glass or is strong enough to overcome most of the negative pressure in the bottle.

Constipation

Constipation is a frequently heard complaint. It is often a source of worry to the mother, who credits it with great importance, and a source of annoyance to the physician, who usually credits it with small importance. The subject has already been touched upon in connection with air swallowing.

While constipation may come with many conditions and is a symptom of several diseases, the most common cause in the normal infant is insufficient caloric intake. For an infant on a formula, the simplest method of increasing caloric value is to increase the carbohydrates and, in many instances, this is the method of choice since carbohydrates are more laxative than milk. There are times when another method would be preferred. For example, if the formula does not contain adequate milk, it may seem desirable to increase the proportion of milk first.

In young infants, both bottle and breast fed, additions or increases in cod liver oil and orange juice, when this seems desirable, may make appreciable difference in caloric intake. For infants two or three months of age, who are already taking large amounts of fairly concentrated formula, it is often preferable to start cereal feed-

ing. The baby is not ordinarily given cereal at two months of age but large, rapidly growing infants, who apparently are not receiving sufficient calories from a seemingly adequate formula, will usually take cereals without difficulty.

Prune juice may give temporary relief but it does not correct the trouble, which recurs when the infant becomes accustomed to the laxative effect of the juice. When prune juice is substituted for orange juice the infant is deprived of his source of vitamin C and the additional calories obtained from the prune juice are not enough to make any appreciable difference.

Use of laxatives should be avoided because they do not correct the difficulty and are liable to be irritating and habit forming. In addition, laxatives containing mineral oil may be actually dangerous because of their ability to absorb vitamin A and thus rob the infant of a larger amount of this important vitamin than he obtains from his diet and also because they may cause lipoid pneumonia.

Use of Feeding Cards

In these busy times there are still some physicians who attempt to give the mother either written or verbal instructions as to all articles of the infant's diet. This seems unnecessarily time-consuming when numerous printed cards, listing nearly every article of diet, are available. The physician need only scratch out here, underline there, and add a word or two in order to fit the card to each individual case.

The feeding cards prepared by the Georgia Department of Public Health have the value of being non-commercial, of recommending nutritious foods which are commonly used in Georgia, and of being kept up to date. These feeding cards are available for use of Georgia physicians if they desire them.

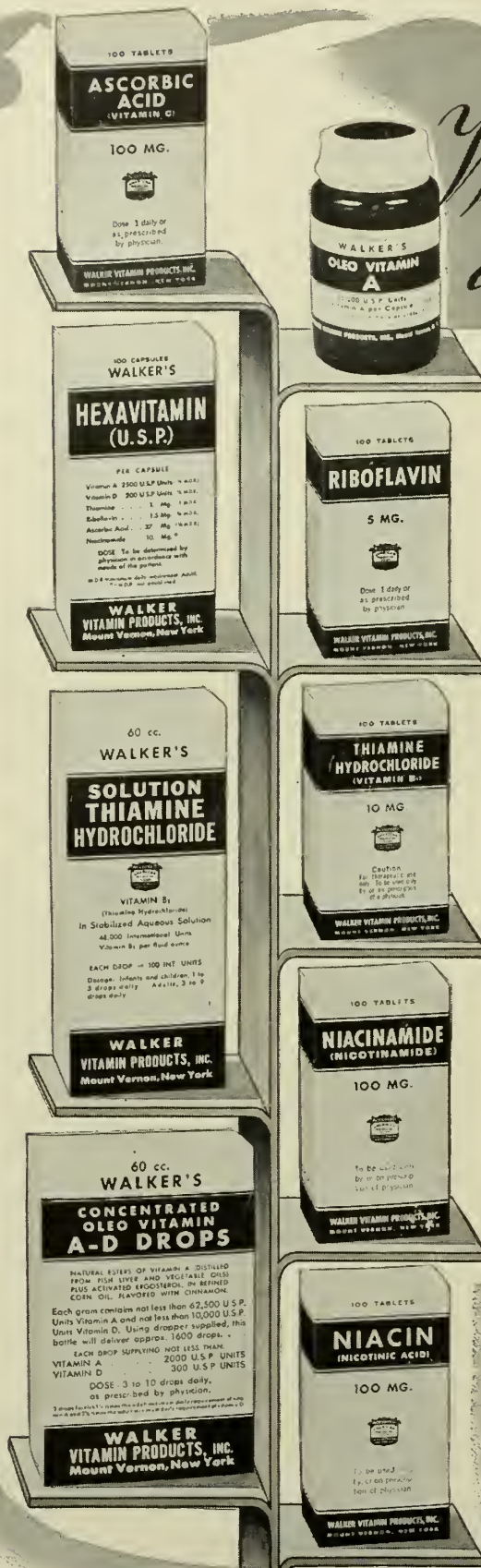
In conclusion, it is hoped that this discussion and simple explanation of two of our most common feeding problems in normal, well babies may have been of some aid to fellow sufferers.

PAUL R. ENSIGN, M.D.,

Georgia Department of Public Health.

WANTED: One resident physician for Georgia State Tuberculosis Sanatorium, Alto, Georgia. Address inquiries to Dr. H. E. Crow, Medical Superintendent.

OUR ADVERTISERS HAVE BEEN GRACIOUS IN THEIR SUPPORT OF THE JOURNAL PLEASE REMEMBER THEM WHEN PURCHASING YOUR SUPPLIES



*Walker vitamins
are good vitamins*

... Good for physicians to prescribe because they fill real therapeutic needs with efficiency, and conform to the highest ethical standards of quality. Good for patients to take because careful laboratory control assures consistent uniformity of vitamin potencies, and because they are convenient to take. Good also, because they offer physician and patient alike, pharmaceutically elegant vitamin preparations at commendably low prices.

COUNCIL ACCEPTED TABLETS

Thiamine Hydrochloride (1 Mg., 3 Mg., 5 Mg., 10 Mg.)	Riboflavin (1 Mg., 5 Mg.)
Ascorbic Acid (25 Mg., 50 Mg., 100 Mg.)	Niacin (25 Mg., 50 Mg., 100 Mg.)
Niacinamide (25 Mg., 50 Mg., 100 Mg.)	

SOLUTIONS

Solution Thiamine Hydrochloride (Oral)
(100 I.U. per drop)

Concentrated Oleo A-D Drops
(2000 I.U. A and 300 I.U. D per drop)

CAPSULES

Oleo Vitamin A Capsules 25,000 I.U.
Nexavitamin U.S.P.

Walker

VITAMIN PRODUCTS, INC.
MOUNT VERNON • NEW YORK

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, March, 1945

Number 3

THE CHOICE AND PROPER USE OF INTRAVENOUS FLUIDS

THOMAS HARROLD, M.D.
Macon

Perhaps some explanation should be offered for the presentation of a paper on such a commonplace affair as the use of intravenous and subcutaneous fluids. Looking back over the history of the development of surgery since the discovery of anesthesia, one is struck by the fact that practically all of the basic technical procedures in use today were discovered and carefully described before 1900. However, their usefulness was greatly limited by the inability of patients to withstand the shock produced by these formidable operations and by an ignorance of the changes in the nutrition and chemistry of the body produced by disease and injury. The proper preparation of patients for operation and the post-operative care of patients lagged far behind the technical development of surgery. The use of normal saline solution as a hypodermoclysis to combat dehydration was a great advance and proved life-saving in many instances. Next came the safe use of blood transfusions to correct anemia or to replace losses from hemorrhage, although for many years it was used in quantities that frequently were "too little and too late." Next to come into widespread use were solutions of glucose in varying strengths, either alone or in combination with sodium chloride and various other crystalloids. Here the physiologic chemists came into their own and the complexity of their metabolic studies, and of the methods recommended for the correction of the abnormalities discovered, served, at times, chiefly to baffle, confuse and discourage

the average surgeon and practitioner who had neither time, training nor facilities for carrying out such elaborate studies and computations. The last great milestone — the widespread use of blood plasma — has come only in the last few years.

In this paper I shall limit my discussion to surgical problems. It is hoped that a review of this important field of therapy may serve to point out some common misunderstandings and to clarify and simplify the use of these important materials. It is sometimes forgotten that the natural way for human beings to obtain fluids of all kinds is by drinking them and absorbing them through the intestinal mucosa! This mechanism contains safety valves and regulatory devices too numerous to mention that are far superior to our chemical and technical skill. Many patients, especially those with burns, can take some or even large quantities of fluids by mouth long before the enthusiasts of intravenous therapy give them a chance to do so.

Here are some of the important landmarks in relation to body needs and fluid replacement in patients in shock and unable to take food or fluids by mouth as estimated by Collier and Maddock:²

1. At least 3500 cc. of water containing glucose (and in some cases salt) are needed each day. This is to provide for excretion of 1500 cc. of urine and the loss of water in perspiration and in respiration.

2. Replacement of the approximate quantity of fluids lost through vomiting, diarrhea, fistulas, etc.

3. The necessary minimal output of urine per day is 600 cc., with a specific gravity of 1030. A larger quantity with lower specific gravity is highly desirable.

4. The total amount of plasma in the body is estimated at 3500 cc., which is about 45 per cent of the total quantity of blood.

Normal Saline Solution

The greatest field of usefulness of this solution is as a hypodermoclysis, as it is the most easily and quickly absorbed of all solutions when injected under the skin. It serves to correct dehydration, especially when due to vomiting with the consequent loss of chlorides in the vomitus, and is especially useful in infants and small children when intravenous therapy is difficult and in adults when additional volume above that obtainable by the intravenous route is desired. It should be used chiefly in acute conditions before severe alterations in body chemistry have taken place. Its use in large quantities alone or over a period of several days is to be avoided as an excess of salt is likely to accumulate in the tissues with resulting edema and a withdrawal of blood plasma from the circulation, with resulting aggravation of the dehydration.¹ In a paper read before the Southern Surgical Society in December, 1943, and now in press, Dr. Frederick A. Collier states:⁴ ". . . There are many individuals who are incapable of tolerating relatively small excesses of salt solution during the immediate post-operative period." He advises that no isotonic salt solution be given the day of operation or for two days thereafter. He states that the clinical condition of the patient and his clinical response to the administration of salt solution are of more importance than blood chemistry determinations. If kidney function is not impaired, salt solution is very well tolerated as any excess quantity of salt will be excreted in the urine. In the presence of depressed urinary output to less than 1000 cc. per day salt solution must be used carefully. Edema usually indicates an excess of salt in the tissues.¹

One of the chief objections to the use of fluids subcutaneously is the fact that they are frequently given much too rapidly, so that the tissues are overdistended and absorption greatly delayed — often for twelve or twenty-four hours. Of course, puddled fluid under the skin is of no value to the patient, but most nurses and many doctors assume that the patient has received the fluid as soon as the needle is withdrawn from the skin. To be effective, hypoder-

moclyses must be given slowly. It is actually harmful to give it faster than it is absorbed and this frequently means six or eight hours' time for every 1000 cc. This is tedious for the patient, the nurse and the intern and I fear is rarely accomplished. Recently Finley³ has advocated the introduction of fluids under the fascia lata on the lateral surface of the thigh and states that absorption takes place as rapidly as if the fluid were given intravenously. I have had no experience with the method but it will be a great help in those patients who have no veins. I do remember one most unhappy experience with an extensive abscess under the fascia lata.

Five Per Cent Glucose in Distilled Water

This solution is slightly hypertonic but glucose is so easily and quickly used by body tissues or stored in the liver or excreted in the urine that very little if any hypertonic effect is produced by a solution of this strength unless it is given very rapidly. Glucose is classed as a crystalloid and it disappears from the blood stream quickly but it is utilized or stored by the body and does not remain in the tissues and produce edema as salt does. Therefore, in addition to providing a certain quantity of easily available energy in the form of glucose, water is left in the blood to combat dehydration and stimulate kidney function. As a kidney stimulant it is superior to salt solution, for, as just pointed out, after the glucose is utilized only water remains in the blood and water is a most powerful stimulant. Someone has remarked that it has taken doctors a long time to learn what sailors have always known, that when a man is thirsty (or dehydrated) he needs fresh water — not salt water.

Glucose solution given intravenously to a person in shock does produce a temporary rise in blood pressure but both glucose and water disappear from the circulation so rapidly that the pressure is not maintained if the cause of the shock is still active.

The chief actions of glucose therefore are:

1. To provide some quickly available food or energy.
2. To replace water lost by vomiting,

sweating, diarrhea, or otherwise.

3. To stimulate kidney function.

Five Per Cent Glucose in Normal Saline

This is a splendid general purpose solution and when the temporary use of only two or three thousand cubic centimeters of solution is necessary, it is probably ideal. However, it should be remembered that it contains the same amount of salt as does simple normal saline solution and therefore is subject to the same limitations. The glucose provides some available energy to replace body reserves depleted during an operation and before food can be taken by mouth. The water is needed to replace the large quantities lost in perspiration during most operations. I am convinced that most of our operating rooms are kept too hot during summer and winter and that many of our patients (and surgeons) leave the operating table and room in a state of heat exhaustion rather than surgical shock. For this reason most of my major surgical patients receive at least 1000 cc. of 5 per cent glucose in normal saline as soon as they return to their rooms. A great reduction in postoperative nausea and an early excretion of urine results from this procedure.

Hypertonic Solution of Salt and Glucose

When solutions of ten and twenty per cent glucose or five per cent salt are given intravenously the first thing that happens is that water is brought into the circulation from the tissues to reduce these solutions to isotonic levels. It is true that this does tend to produce an increase in the output of urine but the extra water excreted is forcibly drafted from tissues that are already dehydrated. Stimulation of the kidneys is better and more safely produced by the use of three or five per cent of glucose in distilled water, which does not cause a withdrawal of water from dehydrated tissues.

Blalock says: . . . "There are few indications for the use of hypertonic solutions in the treatment of peripheral circulatory failure. The tissues are already in a state of dehydration and there is no point in increasing this further. It is better to give larger quantities of isotonic solution."¹

Bayliss, the physiologist, says: "On the whole it would appear that experimental evidence does not warrant much reliance

being placed on hypertonic salt solution."

In my opinion far too much hypertonic glucose solution is being used. Many doctors seem to think that the sicker or more profoundly shocked a patient is, the stronger the intravenous solution should be. They advance from five to ten to twenty to fifty per cent glucose as the patient's condition becomes more desperate without realizing that this program usually hastens rather than prevents the ultimate collapse of the unfortunate individual. If a reasonable quantity of isotonic glucose or saline does not bring about the desired improvement, plasma or whole blood transfusion — not hypertonic solutions — is needed.

Hypertonic solutions have a place in the treatment of head injuries with an increase of intracranial pressure. A decrease in pressure is obtained by this method, which is often dramatic and sometimes lifesaving, but it must be used with great care and good judgment *after* the patient's condition has become stabilized, otherwise the reaction which frequently follows temporary improvement leaves the patient in even worse condition than at first. It should not be used in the first few hours following the injury or until cessation of the intracranial hemorrhage is evident. It is sometimes used to tide over a temporary crisis while preparations for some more permanent type of relief of pressure are being made.

Occasionally when severe acidosis does not respond to the administration of glucose and blood, sodium lactate solution intravenously may be of value.

So far we have dealt with the replacement or supply of water, salt and glucose to the patient unable to take them by mouth. Of equal or greater importance is the replacement of hemoglobin and blood proteins when they are needed.

Most people, when they are anemic, are also in need of plasma protein but the reverse is not necessarily true, as for instance in severe burns and intestinal obstruction where there has been no loss of red blood cells but where much of the blood plasma has escaped into the burned tissue or into the lumen of the obstructed bowel. It should not be forgotten that the fluid in the ob-

structed bowel is quite similar in chemical composition to blood plasma and that these patients need almost as much plasma as do burn cases. In these cases the use of saline and glucose alone in large quantities is ineffective and may be actually harmful as they dilute such plasma as remains in the blood stream and result in additional injury to the capillaries with consequent further loss of plasma. Whole blood transfusions may be given with advantage because of the content of plasma although the red blood cells are not needed and, if given in too large quantity, may be actually harmful in that the viscosity of the blood is unduly increased.

Although oxygen is carried in the circulation by red blood cells, it must be dissolved in the proteins of the plasma before it can be utilized by the body tissues. This accounts in large measure for the "pick-up" frequently obtained from a transfusion which seems all out of proportion to the small increase of about 5 per cent in the hemoglobin. We have known for a long time that patients with chronic anemias could get along surprisingly well with very low hemoglobin values because their plasma protein was not so greatly depleted. The reverse is not true, for when patients retain all or most of their red blood cells but lose quantities of plasma, as in burns or intestinal obstruction, they immediately go into profound shock due in part to a lack of oxygen — or anoxemia.

Blalock says: "Protein is the substance that attracts fluid to the blood stream and holds it there in opposition to the filtration pressure." Plasma proteins are also most important in all other metabolic mechanisms in the blood and its maintenance in suitable concentration in the blood at all times is of paramount importance. When plasma is depleted it may be used more efficiently by the inhalation of oxygen which supersaturates it.⁵

Although simplification of technics and lowering of costs have encouraged the more liberal use of transfusions of whole blood and plasma, I am sure that the commonest error is still "too little and too late."

Efforts are now being made to find a solution of gelatin, beef blood plasma or some

other protein which can be given intravenously as a replacement of lost plasma protein. Such solutions are still in the experimental stage and reactions are frequent and severe. When present difficulties are overcome these substances will be most useful.

As examples of what seems to be satisfactory therapy I would cite two recent cases:

A man, aged 60, developed a gastro-jejunal ulcer three years after a gastroenterostomy, which was performed elsewhere for duodenal ulcer. He had several large hemorrhages and there was partial obstruction at the stoma which prevented proper nutrition. After a period of medical care in which every effort was made to improve his general condition, with only fair success, he had to face the prospect of a most formidable operation while still with a moderate anemia and depletion of plasma protein.

Beginning the afternoon before operation he received the following fluid therapy:

4:00 P.M.—500 cc. citrated blood.

8:00 P.M.—1000 cc. 5 per cent glucose and normal saline.

8:30 A.M.—Cannula tied into the vein at ankle and a slow drip of 5 per cent glucose started and continued for two and a half days, except when interrupted by transfusions. Total of 2000 cc. given in operating room in four hours.

9 to 12:15 P.M.—Operation—subtotal gastrectomy with anterior anastomosis and dissolution of old gastroenterostomy.

10:00 A.M.—500 cc. plasma.

11:00 A.M.—500 cc. citrated blood.

12:00 A.M.—500 cc. citrated blood.

4:00 P.M.—500 cc. citrated blood.

Continuous drip of 5 per cent glucose in distilled water, alternating with 5 per cent glucose in normal saline at the rate of 1000 cc. every six hours was continued for forty-eight hours.

The next day 500 cc. citrated blood.

Except for moderate shock at the end of the operation from which he rallied promptly, his post-operative course was smooth and he left the hospital in fourteen days.

A man, aged 27, was brought to the hospital about 4:00 P.M., a heavy bull-dozer having rolled over an embankment and pinned him underneath it. He suffered the following injuries: multiple fractures of the pelvis, involving one hip joint; rupture of the deep urethra in the region of the bladder neck; as well as minor bruises and lacerations. His blood pressure was 30/60 and he was in profound shock.

His fluid therapy was as follows:

4:00 P.M.—Continuous intravenous drip of 5 per cent glucose in distilled water started at the rate of 1000 cc. every six hours. Blood pressure 80/60.

4:15 P.M.—500 cc. of plasma. Blood pressure 100/70.

6:00 P.M.—500 cc. of citrated blood. Blood pressure 100/70.

7:00 P.M.—Suprapubic cystotomy and application of

double spica cast, under gas and ether and with intravenous drip of glucose.

8:00 P.M.—At the end of the operation—Blood pressure 65/40.

11:00 P.M.—500 cc. plasma. Blood pressure 65/40.

3:00 A.M.—Blood pressure 90/65.

7:00 A.M.—Blood pressure 104/60.

10:00 A.M.—500 cc. citrated blood. Blood pressure 115/70.

He was in rather profound shock throughout the first night and probably should have had more plasma or blood. From this time on shock was not a problem and the man made a complete recovery after two months in the hospital, and was accepted for the Army about eighteen months after the accident.

It is not claimed that there is anything especially unusual about these two cases but they are presented to emphasize the relatively large quantities of blood, plasma and fluid that may be necessary or desirable in handling severely shocked patients. The man with the resection of the stomach received a total of 2500 cc. of blood, 500 cc. of plasma, and approximately 4000 cc. of 5 per cent glucose in distilled water and the same amount of 5 per cent glucose in normal saline in forty-eight hours. The second man received approximately 1000 cc. of blood, 1500 cc. of plasma, 2000 cc. of 5 per cent glucose in distilled water and the same amount of 5 per cent glucose in normal saline in twenty-four hours. Each made a gratifying recovery.

Conclusions

The use and abuse of fluids given intravenously and by hypodermoclysis in surgical cases has been discussed and the following points were emphasized:

1. Surgeons are urged to re-examine their own use of fluids and the routines existing in their hospitals.

2. The dangers of too much normal salt solution are pointed out.

3. Hypertonic solutions are rarely indicated.

4. The use of adequately large quantities of blood and plasma when indicated.

REFERENCES

1. Blalock, A.: Principles of Surgical Care, Shock and Other Problems, St. Louis, The C. V. Mosby Company, 1940.
2. Maddock, W. G., and Collier, F. A.: Water Balance in Surgery, J. A. M. A. 108: 1, 1937.
3. Finley, K. L.: Parenteral Fluids, Am. J. Surg. 63: 337, 1944.
4. Collier, Frederick A., et al: Paper read before Southern Surgical Society and now in press.
5. Boothby, W. M., et al: Indications for the Use of 100 per cent Oxygen, J. A. M. A. 113: 447, 1939.

VITAMIN ADVERTISING AND THE MEAD JOHNSON POLICY

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

ACACIA TREATMENT OF NEPHROTIC EDEMA

L. L. WHITLEY, M.D.

Athens

A patient suffering from nephrosis, or from the nephrotic state of chronic glomerulonephritis, has as his predominant symptom edema, which is characteristic of this clinical entity. Not only is it the main symptom, but it is the outstanding feature of his illness, which keeps him an invalid and prevents his maintaining a normal or nearly normal economic and social existence. When the nephrotic features of glomerulonephritis predominate, hypertension, with its accompanying symptoms due to vascular changes in brain, heart and kidneys, is rarely present. Renal function is usually good and there usually is no retention of nitrogenous matter in the blood. There is little or no anemia. In other words, except for the generalized edema and the symptoms secondary to it, the patient usually feels well, and if the edema were absent he could live a fairly unrestricted life. To attain such an end, and to rehabilitate patients who have been so incapacitated, I am presenting an outline of therapy which has proven satisfactory.

Without going into detail, the edema of nephrosis is the result of retention of water and accumulation of an excess of sodium chloride in the tissues. These changes are brought about by loss of protein in the urine or lack of protein in the patient's diet or, occasionally, both. This results in a decrease in the concentration of serum protein, a subsequent decrease in colloidal osmotic pressure of the serum and a tendency to edema formation and the retention of salt in the tissues of the body.

The following significant laboratory findings are present: albuminuria, a decrease in the concentration of plasma protein and an increase in the amount of sodium chloride in the plasma and tissues. The colloidal osmotic pressure of the plasma (normal, 21.4 mm. of mercury or 360 mm. of water) is decreased. Anemia, definite hematuria

Read before the Medical Association of Georgia, Savannah, May 11, 1944.

and pronounced retention of nitrogenous waste products usually are absent. Hypercholesteremia is present and the basal metabolic rate usually is low. Vascular changes are rare and occur only in cases in which there is extensive glomerular involvement. There is a decrease in plasma volume.

Since the renal lesion cannot be attacked directly, some means of eliminating the sodium chloride and water from the body through the urinary tract must be employed. The serum protein must be augmented. The intake of water and salt must be restricted. Although modified for each case, an outline of treatment based on the clinicochemical factors just mentioned has been found to be most efficacious. It consists of dietetic and diuretic measures which restore the physicoelectrolytic balance in the body.

Diet

The patient is instructed to use a diet containing 100 to 125 Gm. of protein daily. It is salt free except for the natural salt contained in the food, and contains between 1,000 and 1,500 cc. of fluid. If his edema free weight is normal, the diet furnishes approximately 2,000 calories. It may be supplemented by any reliable vitamin concentrate. An adequate, healthful diet is as essential in the treatment of this disease as in that of any chronic illness.

Diuretics

The diuretic agents can be divided into two groups: (1) Those which have a direct action on the kidneys, such as mercurial preparations, potassium and ammonium salts, caffeine derivatives, concentrated solutions of dextrose, and (2) those which act by affecting the colloidal osmotic pressure of the blood, such as whole blood or plasma, which should be administered by transfusion, and acacia, which should be administered intravenously. The latter produce diuresis by increasing plasma volume and by promoting a saline diuresis as well as by raising the colloidal osmotic pressure.

The use of acacia in the treatment of nephrotic edema is still considered by some to be a rather heroic measure, to be employed only under strenuous circumstances. But it has recently been reported that it is a reliable and reasonably safe procedure.

In all cases the diet yielded 2000 calories a day and contained from 100 to 125 Gm. of protein and from 800 to 1,200 cc. of fluid. No salt was added to the food in preparation. Each patient received 9 Gm. of potassium nitrate daily, and was given iron and vitamin concentrates as needed.

Each patient received a minimum of three intravenous injections of 500 cc. of a 6 per cent solution of pure acacia in a 0.06 per cent solution of sodium chloride at intervals of from one to two days. In some cases more acacia is required to obtain the desired effect. The concentration of acacia in the serum was determined one day after the last injection. If the concentration of acacia was 2 Gm. or more per hundred cubic centimeters of serum, further treatment with acacia was not employed. Otherwise the administration of acacia was continued not only until the patient was free from edema but until the concentration of acacia in the serum reached a satisfactory level. A few patients suffered slight reactions, consisting of mild headache, backache or feeling of constriction in the thorax. All were relieved by slowing the rate of flow of acacia into the vein, or by administration of small doses of ephedrine.

Careful examination was carried out in all cases for active foci of infection. Several patients had infected teeth extracted or underwent tonsillectomy during their hospitalization. While this report is not directly concerned with the bacteriologic aspect of nephritis, it is known that streptococcic infections can be serious etiologic factors in acute glomerulonephritis and can precipitate acute exacerbations of chronic glomerulonephritis, therefore focal infection should be eradicated in all cases.

When ready for dismissal from the hospital each patient was instructed about a proper diet and was advised to follow this diet and to take potassium nitrate until advised otherwise by the physician in his home locality. The diets of those whose nutritional state was poor were augmented by vitamin concentrates and iron.

Report of Cases

Case 1—A girl, aged 14, was admitted to the hospital from an ambulance July 23, 1943, for treatment. She had suffered from congenital heart disease and kidney troubles since birth.

Urine showed 4 plus albumin, 1 plus sugar and a specific gravity of 1025; acid reaction. Blood showed: hemoglobin 82 per cent; white cells 11,200, neutrophils 88 and lymphocytes 12.

She was given 400 cc. of 6 per cent acacia intravenously every day for four days and potassium nitrate gr. 15, bicarbonate of soda, gr. 10, and phenobarbital gr. $\frac{1}{2}$ three times daily, with $\frac{1}{2}$ gr. of the latter at bedtime; and 12 cat units of digitalis every day for four days. Liquid diet. On the fifth day acacia was discontinued and 2 cc. of salyrgan were given intravenously every day for the next four days. Digitalis was reduced to $1\frac{1}{2}$ cat units a day on the fifth day.

Her temperature, on July 23, rose from 96 to 97 and then came back to 96.6. On July 24 temperature was normal. On July 25 temperature was 99.6. July 26, 97.8; July 27, 99.8, and the rest of the time it was normal.

Her pulse rose from 60 to 130 on the first day, and the following days it rose from 110 in the morning to 130 in the afternoon; from July 27 on the rate was nearly normal.

On July 30 the patient was dismissed; no appearance of edema. Today she is developing into a healthy young girl with no edema present.

Case 2—A man, aged 71, was admitted to the hospital Jan. 12, 1944. Chief complaint: shortness of breath and edema of abdomen and feet. Patient was well until about 15 years ago when he noticed edema of ankles. Two years ago abdomen became enlarged and distended. He went to several physicians and hospitals, was tapped several times and was given drugs.

Urine showed 4 plus albumin, and no sugar. Blood pressure was 200/150. He was given 500 cc. of 6 per cent acacia in 0.06 per cent saline intravenously every day for four days and 12 cat units of digitalis every day for four days. Potassium nitrate gr. 15, bicarbonate of soda gr. 10, phenobarbital gr. $\frac{1}{2}$ three times a day, and phenobarbital gr. $1\frac{1}{2}$ at bedtime. Liquid diet. On the fifth day acacia was discontinued and 2 cc. of salyrgan were given intravenously every day for the next four days. Digitalis was reduced to $1\frac{1}{2}$ cat units a day.

Patient was discharged on February 15, with no edema present.

Case 3—A woman, aged 28, entered the hospital with a cardiovascular-renal breakdown, for which she had been admitted numerous times.

Urine showed 2 plus albumin, with no sugar. Temperature was practically normal during entire stay. Patient's abdomen was tapped several times, the third day, obtaining about 20,000 cc. of a straw colored fluid.

On entrance she was immediately started on 500 cc. of 6 per cent acacia intravenously every day for four days and 12 cat units of digitalis every day for four days. Potassium nitrate gr. 15, bicarbonate of soda gr. 10, and phenobarbital gr. $\frac{1}{2}$ three times a day. Phenobarbital gr. $1\frac{1}{2}$ at bedtime. Liquid diet. On the fifth day acacia was discontinued and 2 cc. of salyrgan were given intravenously every day for four days. Digitalis was cut to $1\frac{1}{2}$ cat units. Pulse and respiration practically normal.

Patient was discharged with no edema present.

I am indebted to Dr. Henry J. Lehnhoff, Jr., of the Mayo Clinic and Dr. Melvin W. Binger, Rochester, Minn., for some of the information furnished in this report.

AMERICAN MEDICINE TOMORROW

MAC F. CAHAL,

Chicago

Executive Secretary

American College of Radiology

In his excellent book comparing the theories of Oswald Spengler and Raymond Pearl, "Today and Destiny," Edwin F. Dakin expresses a truism that is of particular significance for doctors in these dynamic times: "Any concept — economic, political, or cultural — which leaves its possessor wholly unprepared for tomorrow is of doubtful validity. Conversely, men who are not surprised when the future comes, lie very close to the truth."

Dr. Lowell S. Goin, president of the American College of Radiology, was pleading for a true concept of the future when, in a recent letter to Members and Fellows of the College, he warned of impending social changes that would almost certainly result in new methods of distribution for medical services. He urged radiologists to actively encourage voluntary prepayment plans for medical care, sponsored by medical societies, as the soundest and most desirable method among the many that have been proposed. At the same time he warned that some form of socialized medicine, embodying compulsory health insurance, is not an inconceivable eventuality.

Dr. Goin's concern would seem to be justified by what most observers have recognized as an increasing pressure of public opinion. The attitude of the public was succinctly expressed by *Fortune* magazine in its December issue: "The state of medicine in the United States is a social problem because the country's conscience has made it so . . . people who cannot find or pay for proper medical care are resentful."

I have been sharply criticized in some quarters for a statement in my annual report to the College two years ago in which I referred to the powerful social forces at work throughout the world and their manifestation in agitation for socialized medicine in this country. I remarked that there

Presented at the annual meeting of the Board of Chancellors of the American College of Radiology in Chicago, February 8, 1945.

was a growing conviction among medical men that a head-on opposition to this unmistakable trend would be as unwise as it would be futile. Subsequent events have proved, I believe, that the demands for improvements in the distribution of medical services must be met, either by voluntary plans for prepayment or, if not, then by compulsory health insurance. It seems unnecessary to recite the extensive evidence that this is so. A half dozen public opinion surveys have revealed a definite public demand for insurance against medical costs.

Brigadier General Fred W. Rankin, in his presidential address before the American Medical Association House of Delegates last year, called upon the medical profession to recognize the gathering momentum of trends that are "directed toward some form of national health service as an integral function of the state." He made a plea that they be regarded not in the light of apostasy, but rather in the light of realism.

Dr. Allan Gregg, whose words carry considerable weight in the medical world, has uttered a similar warning. "The danger for medicine in America lies in failure to acknowledge and to study the sociologic aspects of medicine — the social matrix. We are loath to see that research and teaching, as well as the practice of medicine, will change when change comes in the prevalent interpretations of the role of government and the structure of our society," he says.

It would appear, therefore, that if we are not to be unprepared for tomorrow, we should give consideration in our deliberations to the likely effects of all the various proposals for changes in the economics of medicine. It is a poor general who fails to consider the probable results of every possible contingency that may alter the existing situation.

In our efforts to peer into the future of medical practice in the United States I think we should keep one very important point clearly in mind. It is this: Every system of compulsory health insurance in all the countries of the world has been built upon existing agencies for the distribution of medical care. On the basis of history, therefore, we can assume that, if a system

of compulsory health insurance is adopted by Federal or State governments in this country, existing plans for the application of the insurance principle to payment for medical care would be utilized by the state. The obvious corollary is that medical practitioners would carry on under the state plan much as they did under the voluntary plans which preceded it. This has been almost the universal experience in European systems.

Writing on the "Origins of Health Insurance," in their excellent book on this subject Simons and Siani show that compulsory health insurance is built out of three existing institutions: insurance or prepayment plans, the state, and the medical professions. "The relations, reactions, and relative strength of these determine much of the character and results of the operation of existing insurance systems," they say. Their study of compulsory health insurance throughout the world leads them to conclude that pre-existent voluntary prepayment plans have dominated the state systems which followed.

Douglas and Jean Orr, in their book on the British experience with health insurance, point out that the form which the national health system of England finally took was determined by the "friendly societies" which had existed for many years as voluntary plans for prepayment to meet the costs of sickness.

Sir William Beveridge, in his epoch-making report on social insurance in England, observes the part which the voluntary plans have played in setting the pattern of the government system. He contemplates, though with frank displeasure, that they will continue to be utilized as distributing agencies in the expanded system which will undoubtedly be adopted in Great Britain.

He implies, incidentally, as have others before him, that voluntary sickness insurance promotes, rather than deters, the adoption of compulsory systems. In 1909 David Lloyd George pointed to the "friendly societies," which were comparable to our present prepayment plans, as proof of the feasibility and desirability of compulsory sickness insurance. The National Health Insurance Act came three years later. It is

significant, perhaps, that efforts to enact compulsory insurance laws in our own country are today most concentrated in the two states with the oldest and largest voluntary medical service plans, California and Michigan.

We all hope that voluntary prepayment plans, sponsored either by medical societies or commercial insurance carriers, will meet the palpable demand of the public for relief from the unpredictable financial burdens of illness. If they do not, the lessons of history teach us that organized medicine has yet another compelling reason for extending these plans as rapidly and as widely as possible. Once firmly established, they would set the pattern and determine the methods to be followed in the event a compulsory system is adopted.

Now, in the light of these considerations, the group hospitalization movement, concerning which organized medicine has been exceedingly circumspect, acquires a new importance that tends to justify medicine's diffidence. Are the Blue Cross plans to duplicate the history of England's friendly societies? Two facts lend credence to an assumption that this is altogether possible.

First, a determined effort is being made by directors of Blue Cross plans to extend their benefits to include complete surgical or medical care. Second, Blue Cross plans would almost certainly be preserved and integrated in a compulsory sickness insurance plan.

The first of these statements will be promptly denied by Blue Cross leaders. But the facts speak for themselves. In Delaware, the Blue Cross has already been expanded to include cash benefits for surgical care. It is administered by a Board of Trustees on which there are two hospital representatives for every doctor. Also in West Virginia and North Carolina hospital service plans have assumed full control of medical care plans.

The American Hospital Association, at its recent annual meeting, considered recommendations from several speakers for "extending prepaid hospital plans to cover out-patient care." At the same meeting the Hospital Service Plan Commission approved a proposed model enabling act for compre-

hensive health service plans which would require, among other things, that any plan incorporated under the act be controlled by a board composed of one-third hospital trustees, one-third doctors, and one-third lay representatives of the public. In the course of the discussions, Mr. Louis H. Pink, president of Associated Hospital Service of New York City, urged expansion, without delay, of Blue Cross to include the cost of medical care.

In Philadelphia, where the medical society several years ago fought a bitter and unsuccessful battle to exclude radiology and pathology from the hospital service plan, a proposal has very recently been submitted to add complete medical care to Blue Cross benefits. The proponents candidly recommend repeal of the present Pennsylvania enabling act, which requires that a majority of the directors of medical service corporations be doctors of medicine.

Now I desire that I not be misunderstood. Cooperation between hospital service plans and medical or surgical service plans is essential. It is rather generally agreed among hospital leaders that Blue Cross enrollment has about reached its maximum unless contracts for hospital service can be coupled with insurance against medical costs. There is no doubt that the United States Public Health Service will emphasize this fact in the report of a study it is currently making of the movement. Furthermore, it is both logical and economical to delegate responsibility for sale and routine administration of the medical service plan to existing Blue Cross plans which have several years of experience and have acquired trained personnel.

But medical societies which turn over complete control of prepaid medical care to Blue Cross plans that are controlled by hospitals are traveling a dangerous road. They are violating one of the basic principles of organized medicine if they fail to establish a separate corporation to control the medical plan, with a board of directors of which at least a majority are doctors.

Ten years ago the American Medical Association laid down the postulate that: "All features of medical service in any method of medical practice should be under the

control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control." This principle has lost none of its validity.

If anyone is inclined to minimize the importance of this principle, he has but to follow the course of the controversy that has persisted between hospital service plans and the organized medical profession over the inclusion of certain medical services as a part of hospital care. For ten long years county, state and national medical organizations have insistently demanded that radiology and pathology be excluded from Blue Cross benefits. Everyone knows that the reaction of hospitals to these unequivocal demands has been one of polite indifference. What makes anyone think they would follow the dictates of the medical profession concerning other branches of medicine, once they were in control of medical service plans?

Constantly during recent years the American College of Radiology has warned that medicine would sacrifice a basic principle if it yielded to the adamant demand of hospitals that they be permitted to include radiology and pathology in Blue Cross benefits as a part of hospital care. Too often our admonition that this would open the door to further encroachments by which hospitals would assume added prerogatives in the delivery of medical services, has fallen on unheeding ears. Now, as one medical editor has sardonically remarked, "The beans are on the carpet, spread out for all to see."

The second fact stated above, that Blue Cross plans would be integrated in a system of compulsory insurance is likewise more than a mere assumption. Witness the curious tergiversation that has taken place in Rhode Island. Not long ago the governor of Rhode Island proposed a law of compulsory hospitalization insurance in his state. Promptly Blue Cross executives all over the country assailed the proposal as "un-American" and "regimentation." But, when the governor publicly announced that he contemplated the use of Blue Cross as an agency under the system, opposition quietly died.

The Wagner-Murray-Dingell bill, as you

know, authorizes the Surgeon General to "negotiate agreements . . . with private agencies or institutions . . . to utilize their services and facilities . . ." *"In response to a question from hospital spokesmen, Surgeon General Parran has already expressed the view that this would include Blue Cross plans."*

I would point out that this provision in the bill would also permit medical service plans operated by medical societies to enter into contracts for rendering services to beneficiaries. Significant also is the provision in the Wagner bill which permits the practitioners in each area to elect the method by which payment shall be made for services.

Does this not offer sufficient reason for medical societies to set up their own plans for prepaid medical care? Surely the leaders of medicine can see the wisdom of establishing proper precedents now.

I have attempted here to present a point of view, which I think carries profound consideration for American medicine. I have not said that voluntary plans of sickness insurance will be superseded by a compulsory system. I honestly do not believe they will be. But, as my friend, A. M. Simons has wisely said, social experiments invariably establish patterns of precedent that are seldom completely reversed. In these dynamic times we have extra reason to be vigilant.

The future faces American medicine. Precedents are being established that will have permanent influence on the system of medical practice in this country for many years to come. From the leaders of thought in organized medicine the highest order of statesmanship and sound judgment is needed.

WOMEN MEDICAL OFFICERS

There are currently 74 women medical officers serving in the Army, according to the Office of the Surgeon General. Of this number four are majors, 36 are captains and 34 are first lieutenants. They have been certified as internists, neuropsychiatrists, obstetricians, gynecologists, pathologists, radiologists and anesthetists, and the Army has given them assignments in line with their specialties at general, regional and station hospitals as well as at the two WAC training centers. Seventeen of these women medical officers are now serving overseas.

THE PRESIDENT'S PAGE

NO STATE CONVENTION THIS YEAR

The ODT has turned thumbs down on our annual meeting of the Medical Association of Georgia for this year! To be sure a mental note of the hundreds of conventions affected, with the thousands attendant upon them, congesting traffic, crowding hotels and gobbling up food that is becoming scarcer and costlier daily, forces us to agree that this decision is the better part of wisdom.

For many of us this will be a bitter disappointment — I won't anymore feel that summer has properly appeared than the little boy whose "Ma won't let him go to the ole swimmin' hole." During my thirty-odd years of practice nothing has stimulated me more than the annual injection of fellowship, scientific discussion, and high ethical ideals received at the meetings of the Medical Association of Georgia, but far be it from any Georgia doctor to demur against any of the decisions made in favor of the war effort. We agree with the old Persian: "Thinking well is wise; planning well, wiser; doing well wisest and best of all." And there is a very satisfactory substitute for the State conclave.

District Medical Society Meetings

The ODT decision that fifty or less may hold a meeting will permit district gatherings. It is urged that all district medical associations not having already held spring sessions do so during April and May, planning then for a fall session. This will keep

us all in touch with what is transpiring and keep us united against any insidious or harmful trespassers, be they even so unintentional as indifference.

Some districts have had no meetings since war was declared. This makes a weak link in the state organization. Being deprived of the annual session is a challenge to these groups to rise to the emergency and have enthusiastic meetings now. The regular county medical society meetings are more important than ever.

It is very fine to have well planned programs and formal parliamentary meetings, but where there can be gathered together only three, eight or a dozen doctors in a county, even though they see each other fairly constantly in the rush of life, nothing can be more helpful than eating a meal together — to break bread with another has always been a gesture of friendliness — and then to get off at a good start to reviewing certain cases that have come under notice during the month, with deductions that the group may add. The "Big Three" who fly the girth of the globe to get together to discuss this sick world are no more important in your county than the three or five doctors who are responsible for the healing of its sick people; and as surely do we need the wisdom and experience of each other as do these men with great responsibilities who get together despite distance and dynamite.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

MARCH, 1945

**IN DEFENSE OF
GEORGIA'S STATE BOARD OF
HEALTH**

(Jan. 29, 1945)

Commenting on the attack made on the State Board of Health and its director, Dr. T. F. Abercrombie, by Speaker Roy Harris of the Georgia House of Representatives, the executive committee of the Medical Association of Georgia, composed of Dr. Cleveland Thompson, Millen, president; Dr. Steve Kenyon, Dawson, chairman of the Association's Council, and Dr. Edgar Shanks, Atlanta, secretary, stated:

"Public health in Georgia has a long and honorable history, and this is due to the interest and work of physicians and other persons. If Speaker Harris will examine the record he will find that as far back as 1804 the physicians of Savannah made a notable contribution to the welfare of that city's people through their public health work in preventing the spread of yellow fever. About the same time the physicians of Mr. Harris' home city, Augusta, made a similar contribution; and a few years later there was established in Augusta the State's first medical college, which is now 117 years old and which continues to render service to the people of Georgia and the nation.

"Unfortunately, progress in public health has been slow, but fortunately public health can be bought. While it is an intangible commodity and its value cannot always be determined in dollars and cents, examination of morbidity and mortality records shows the value of our constant attention to public health problems.

"Despite the creditable record of Georgia's public health department, there have been times when the department or some of its personnel did not please all of the people; and there have been times when certain members of the General Assembly of Georgia failed to understand either the motives or the activities of the department. But constant progress in public health in Georgia has been made, and greater progress in the prevention and cure of disease will surely come if the state government will continue its support to the present State Board of Health and its employees, in whom we have full confidence.

"The recent complaint regarding the tuberculosis unit at Alto has not been investigated by us, but we know the situation there will im-

prove as soon as adequate employees can be found to operate that institution at full capacity. Other tuberculosis units must be built and maintained if we are to control the spread of this disease. Still other medical units must be built and maintained for chronically ill patients with such diseases as arthritis and heart disease. Finally, the more than eighty Georgia counties which are without hospital facilities of any kind today must plan and build some kind of community health centers, and in this planning and building the State Board of Health can be of inestimable help.

"It is our considered judgment that the General Assembly of Georgia would make a grave error were it to abolish the present board of health and at the same time legislate out of positions numerous faithful and efficient employees of the present health department. To do so would be a tragedy for our State. We also believe that the present law dealing with appointments to the Board of Health is adequate and cannot be improved upon. Finally, we believe that none of the State's health activities should be transferred to the jurisdiction of other State Departments.

"It should be clearly understood that we have no fight with Speaker Harris. Let us hope that he will soon end his fight on Georgia's health department and will join with it and with the medical profession of Georgia in the never-ending fight to curb the spread of preventable diseases, to help alleviate insofar as possible the suffering from any disease, and to help in the building of a state in which all of us will be proud to live."

**SAYS COURTS NEED MEDICAL GUIDANCE
IN HANDLING CRIME AMONG THE AGED**

Because of the relationship of senescence and senility to crime among the aged, there should be a close working contact between physicians familiar with the mental problems of aging and the courts in order that the cause of justice may be best served for those criminals of older years whose actions are affected by senescence or senility, *The Journal of the American Medical Association* advises in its February 24 issue. *The Journal* says:

"The relation between age and crime is significant socially. W. Norwood East emphasizes that most magistrates are not appointed until they have reached middle age; this preponderance of middle age and elderly judges, he feels, may be far from desirable in cases involving juvenile crime. East quotes a circular in 1936 which declared that 'apart from the obvious advantages attaching to quickness of hearing and of sight in a justice, there is the fact that as time goes on men and women justices are apt to lose the freshness of mind and sympathy and the up to date knowledge of social conditions which are of extreme importance for successful work in the juvenile courts.' The particular prob-

lems of the aged or senile person who commits a crime deserve special study. Although this report cites British figures and British problems, there is ample reason to believe that the situation in the United States is in most respects parallel. The trial of aged persons by their contemporaries may be unsatisfactory, East says. Age itself is not necessarily a true measure of senescence, using that word for the normal process of growing old, or of senility, used in a sense of abnormal mental states which sometimes supervene toward the close of life. Consequently special attention should be given to the manner of thought and behavior of the aged. The onset of normal old age, or senescence, is a physiologic condition rather than a pathologic state, and is therefore difficult to determine its onset. The chronologic age is often misleading as an index of the onset of this physiologic process; authorities have placed it in the early forties, at 55, at 65 and probably at many other ages. Most modern students are inclined to agree with the late Sir Humphrey Rolleston that in healthy persons the onset of senescence is so stealthy that it is seldom suspected by the person himself. One man may be senile at 60 while another is vigorous in both mind and body at 80. In criminology the important feature of normal senescence is the degree of control exerted by the will when directed toward the discouragement of illegal acts which would put the interests of the individual ahead of those of society in general. East adds to this the action of the will in encouraging activities which are legal and useful to society, however strongly they may be opposed to the desires of the participant. When the hitherto blameless senescent becomes involved in illegal behavior as a result of mental deterioration, he deserves, East says, the fullest understanding from those who judge him, and this requires insight into the background of his mental life.

"Normal aging passes into senility when the impairment of intellectual, emotional and volitional attributes of mind becomes excessive and the mental activities are imperfectly synchronized with resultant inability to form well considered opinions, to exert sustained effort and when social maladjustment results. The reason senility develops in some persons and not in others appears to depend, at least in part, on the inherent constitutional makeup and degree of cerebral arteriosclerosis present, on the stresses which they have experienced and indirectly on the manner of life. Used in this sense, the term senility would be restricted to senile and arteriosclerotic dementias. Although aged prisoners are generally treated under a milder form of discipline than others, the mental background of the offender before trial is also important but has received less attention than is due it. In matters involving criminal responsibility in the aged, East says

attention must be paid not only to the standards of so-called normal persons but also to the conduct and mental condition of the senile offender during his younger years. Where mental abilities are superior during the prime of life, it is especially easy to overlook perceptible degrees of deterioration due to age because the offender is compared with those of merely average intelligence and ability of comparable years.

"Out of a group of 9,197 prisoners of both sexes in the prisons of England and Wales recently convicted for various offenses, 290 were aged 60 years or over. Of these, 71 were first offenders and 194 had been previously convicted three times or more. The number and proportion of aged persons in the population is constantly increasing. Although the incidence of crime among the aged and senile will doubtless vary in response to hereditary, social and economic factors as well as to age, the problem will doubtless increase more or less consistently. Close working contact between physicians familiar with the mental problems of aging and of the courts is highly desirable in order that the cause of justice may be best served for those criminals of older years whose actions are affected by senescence or senility."

UNITED NATIONAL CLOTHING COLLECTION

Active participation and cooperation of all American business men and women to assure success for the United National Clothing Collection in April, 1945, is solicited by Henry J. Kaiser, West Coast shipbuilder and industrialist, serving as National Chairman of the drive. This drive is conducted in behalf of more than 50 voluntary war relief agencies and United Nations Relief and Rehabilitation Administration (UNRRA). It will be the only collection of clothing for overseas war relief during the spring of 1945.

The urgency of this campaign is testified to through photographs and articles from all the nations involved. In Europe alone, 125,000,000 men, women and children are in desperate need of clothing, shoes and bedding. The suffering and deaths already due to their lack of such essentials cannot help but stir the humane impulse of everyone. But the drive to procure for them 150,000,000 pounds of serviceable used clothing from the attics, closets and trunks of American homes has other significant implications. Such materials will help these stricken war-sufferers to help themselves toward their own re-establishment and, in turn, to help us in creating the peaceful world of the future.

Besides Mr. Kaiser, many other business leaders are serving on the national committee. The service clubs—Rotary, Kiwanis and Lions—with their strong business representation, have spearheaded the formation of local campaign

(Continued on Page 66)

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.
 Corresponding Secretary—Mrs. Alex Russell, Winder.
 Treasurer—Mrs. Ralph Fowler, Marietta.
 Historian—Mrs. W. W. Puett, Norcross.
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.
 Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

Mrs. R. V. Martin, of Savannah, chairman of War Participation, has five goals for this year:

1. Recruitment of cadet nurses, in cooperation with the State Nurses' Association, will again be a main project for War Participation.
2. Cooperation in all forms of war service: Civilian Defense, Red Cross, Blood Donations, and the purchase of War Bonds.
3. Individual records are expected and not activities of the county auxiliaries as a whole.
4. A suggestion was made that a record of the number of hours of war work be taken by the local chairman at each meeting of your auxiliary in order that the annual report be made very promptly and accurately.
5. The A. M. A. has ruled that hours spent in your husband's office is counted as War Participation.

The Woman's Auxiliary to the Randolph-Terrell Medical Society held a meeting recently at the home of Mrs. J. C. Patterson, Cuthbert. The president, Mrs. Leonard Rush Massengale, called for reports from standing committees. Mrs. A. R. Sims, Mrs. J. T. Arnold and Mrs. F. S. Rogers were elected to serve as a nominating committee and presented the following officers for the next year:

President, Mrs. Leonard Rush Massengale;
 Vice-President, Mrs. T. F. Harper;
 Secretary-Treasurer, Mrs. Loren Gary.

An instructive program on health education was presented by Mrs. A. R. Sims. In the absence of Mrs. J. W. Humber, chairman of Research and Romance in Medicine, Mrs. Harper read Mrs. Humber's biography of Dr. Albert Sidney Gilbert of Stewart County, copy of which was given to each member.

Mrs. R. V. Martin, of Savannah, chairman of Research and Romance in Medicine, read a paper on the life of Dr. Eugene Rollins Corson, at the recent meeting of the Woman's Auxiliary to the Georgia Medical Society. The meeting was held at the home of Mrs. E. C. Demmond in Savannah. Two new members were introduced, Mrs. J. L. Southworth and Mrs. C. A. Smith. Mrs. W. R. Dancy, Hygeia chairman, reported 45 subscriptions for Hygeia.

A nominating committee composed of Mrs.

Charles Usher, Mrs. R. E. Graham, Mrs. C. R. Redmond, Mrs. A. A. Morrison, Jr., and Mrs. S. Elliott Wilson was appointed. Mrs. H. M. Kandel announced that the cancer campaign would be put on before the April meeting. Mrs. S. Elliott Wilson announced that Mrs. R. L. Neville will accept the nomination as president-elect to succeed Mrs. E. C. Demmond. The next meeting will be held at the home of Mrs. R. L. Neville in April.

The Barrow County Medical Auxiliary met at the home of Mrs. W. T. Randolph, Winder, Feb. 16, at 10:30 A.M., with Mrs. C. B. Almand, president, presiding. Committee reports included U. S. Cadet Nurse Corps, Mrs. W. T. Randolph, chairman; five girls enlisted during 1944. Legislation: Mrs. E. R. Harris, chairman. Senator R. B. Russell was contacted in regard to Murray-Wagner-Dingell bill. Cancer control: Mrs. C. B. Almand reported \$365.86 contributed by Barrow County citizens. Eight subscriptions were taken for the Hygeia magazine and each member contributed \$1.00 to the Student Loan Fund.

Mrs. S. T. Ross was appointed Doctors' Day chairman.

Following the business session, Mrs. A. B. Russell addressed the meeting, using as the subject, "Romance of Health." The hostess served cold drinks and canapes during the social period.

Mrs. W. T. Randolph, president of the Woman's Auxiliary to the Medical Association of Georgia, announces that the state convention has been cancelled in compliance with the request of ODT.

RISK OF INFANTILE PARALYSIS NO GREATER IN ARMY THAN CIVILIAN LIFE

Despite the huge concentration of men brought together from all parts of the country in Army posts and the combat conditions under which great numbers are living, there is apparently no more danger in the Army from infantile paralysis than there is in civilian life.

The Office of the Surgeon General reports that the number of cases was 3.4 per 100,000 troops in this country in 1943 and 4.0 in 1944. The case fatality rate was 12.1 per cent in 1943. This is similar to the civilian rate for similar ages, and there is a further similarity in the time of year the cases occurred and their geographical location.

There has not been an epidemic of infantile paralysis at any Army post during this war.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta. Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALNUT 8911; residence, JACKSON 7979.

REASONS WHY H. R. 327 SHOULD BECOME A LAW

H. R. 327 is a bill to provide for the establishment of a permanent Nurse Corps in the Veterans Administration, introduced in the House of Representatives by Mrs. Edith Nourse Rogers of Massachusetts on Jan. 3, 1945.

The needs of the Veterans Administration have been publicized extensively, but we believe that there should be greater consideration given and that H. R. 327 should become a law in order to meet these needs. Although the Veterans Administration is granted deferment for its nurses, there is no provision in the proposed draft bill H. R. 2277 for the commissioning of a Nurse Corps for the Veterans Administration, and a provision should be inserted to this effect.

The main reasons why H. R. 327 should become a law are:

1. It would place Veterans' Administration nurses who are eligible for the corps on a par with those of the Army, Navy, and U. S. Public Health Service.
2. It would create a sound opportunity for a career in Veterans' Administration nursing.
3. It would provide the nurse protection, stabilize benefits, and establish high standards for Veterans' Administration nurses.
4. It would give Veterans' Administration nurses needed prestige within the profession.

Under the present Civil Service status there is no safeguard for Veterans' Administration nurses, since Civil Service cannot protect standards and qualifications.

There is no inducement now for a nurse to continue in the service of the Veterans' Administration, since the President's appeal for nurses to care for the men in Army and Navy hospitals, the increase in resignations has been alarming. Is it reasonable to suppose that a man's life is of greater concern to the nursing profession when he is actively engaged in the service to his country than when, as a result of that service, he becomes the responsibility of the Veterans' Administration?

The establishment of a Nurse Corps for the Veterans' Administration will not adversely affect any nurse now in the employ of the Veterans'

Administration; those nurses who do not qualify for the corps will retain their Civil Service benefits.

(The American Nurses' Association is at present preparing to endorse H. R. 1103 and H. R. 1660—to amend the Classification Act to provide for the reclassification of nurses from sub-professional to professional status).

Those nurses who do qualify will, in addition to the benefits stated above, be eligible for the benefits under the G. I. bill—which benefits are now provided for the nurses in the Army and Navy Nurse Corps.

* * * *

H. R. 1284 (printed in February 1945 issue of this Journal Renumbered H. R. 2277).

The bill does not provide, nor does it express a hope for a limited service act for all women.

The bill is not clear as to the commissioning of nurses.

It refers only to registered nurses and it is suggested that appropriate provisions be inserted referring to the particular professional titles protected by state law. It does not appear to provide for deferment on the basis of classifications by the Procurement and Assignment Service. A provision should be inserted directing the Director of Selective Service, in administering the law, to give proper credit to the states for voluntary recruitments. The bill, by cross references to the Selective Service Act of 1940, appears to grant deferments on the basis of family relationships. It should contain specific provisions against discrimination with respect to race, color, creed or sex. No provision is made for the functioning of any voluntary plan. It provides for a preliminary draft of the graduates of the U. S. Cadet Nurse Corps, and it would appear that this would constitute a breach of faith with Cadet Nurse Corps students and would not provide as many nurses in a given period of time as a draft of all eligible graduate registered nurses would provide.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

GEORGIA'S "GI" BABIES

Over 6,000 "GI" babies have been born in Georgia during the period of Sept. 15, 1943, through Feb. 28, 1945. These infants are the sons and daughters of members of the armed forces whose hospital and medical expenses have been subsidized by Uncle Sam through the Emergency Maternity and Infant Care Program, administered by the Georgia Department of Public Health.

This program has been functioning in the State for approximately a year and a half but many physicians are unfamiliar with its purpose and operation and many others have raised questions concerning various phases of the program. This article, therefore, has a three-fold objective, to give something of the background of the program, to give a brief and simple picture of how it functions, and to answer some of the more frequently occurring questions. The over-all objective is to reduce the misunderstanding, misinformation and misinterpretation which has occurred to date.

In discussing the Emergency Maternity and Infant Care Program, the important word to note in that rather formidable title is the first one, "emergency." A state of emergency exists throughout the entire world with the flames of war raging in almost every land. Millions of breadwinners of American families put aside their peacetime lives and marched off to fight the blaze and measures were quickly drawn up and passed by legislative groups to help protect and care for the families they left behind. Among these measures was the Emergency Maternity and Infant Care program, or EMIC as it is usually called, which was designed to render maternity and infant medical and hospital care to dependents of military personnel below a certain pay grade. It was adopted for the duration of the war and six months thereafter.

Concerned with making this program succeed are three groups: the administrative group consisting of the U. S. Children's Bureau and the Georgia Department of Public Health, private physicians, and hospitals or hospital-type facilities. Responsibility is equally divided between these groups and only the cooperation of all makes the program possible. Like a three-legged stool, the weight must be equally borne by each individual leg if the load is to be balanced at all.

Origin of EMIC Program

The EMIC program in Georgia was not born without some severe labor pains. In 1942 Georgia was first advised that a portion of State Health Department federally allotted funds would be withheld for allocation to other states if a maternal and infant care service was not estab-

lished. At that time the funds available were completely inadequate for financing such a service and no program was started. In March 1943 the federal agency secured a deficiency appropriation which made it possible to allot special funds for this maternity and infant care service to the states.

A plan was then drawn up by the State Health Department in accordance with federal regulations, submitted to and approved by the Advisory Committee of the Medical Association of Georgia and forwarded to the U. S. Children's Bureau. For the next six months a minor tug-of-war was waged over revisions and changes in the plan which would make it acceptable to the federal agency. As a result a revised plan did not get under way in Georgia until Sept. 15, 1943.

The difficulties were concerned chiefly with administrative policies. Taking a standardized federal pattern and making it fit 48 states of varying size and shape turned out to be a Herculean dressmaking job. Then, too, the program was a quickly drawn-up emergency measure, new to the Federal Agency, new to the State Agency and spotty with imperfections. In addition, State Health Agencies were not equipped or prepared to handle such a program immediately.

But GI babies were being born and public demand for the service was increasing daily. Service men cared nothing (and who can blame them?) about administrative headaches but were interested in obtaining care for their wives and children. So the revised plan, though containing some provisions unsatisfactory to the medical profession and to the State Agency, was approved so the program could get under way. Approval of the plan by the Council and the Advisory Committee of the Medical Association of Georgia was given with the understanding that the medical profession wished to live up to its patriotic responsibility during the war and that said approval was limited to the duration of the war and six months thereafter.

How It Functions

As an illustration of how the EMIC program operates, consider Private Smith's wife who is going to have a baby. Her monthly allotment check will not stretch to cover the usual expenses entailed but she is advised that the government will see her safely through the baby's birth and any illness the infant might have up to the age of one year. She secures an application blank for maternity care from her local health department. They are also available from Red Cross Chapters, approved hospitals and offices of participating physicians.

She fills out her part of the application and then consults the physician of her choice. If the

physician accepts her case, he completes his part of the form and it is forwarded to the State Health Department. If the application is in order, he is sent a medical record form, together with an authorization for the individual case. Following completion of postpartum examination, the physician sends in a completed case record and is paid for his services in accordance with established fee schedules.

If Mrs. Smith is hospitalized, the necessary details are handled directly with the hospital; this physician designates on the application blank, provided the hospital-type facility is approved to care for EMIC cases.

The same procedure is followed if the baby becomes ill and a physician is called. Applications for maternity care should, of course, be made early in pregnancy and for infant care immediately following onset of illness.

How much will the physician be paid for caring for Private Smith's wife or their sick baby? For services authorized since July 1, 1944, a revised fee schedule pays the physician a maximum of \$50.00 for maternity care. This \$50.00 is divided as follows:

\$12.50 for prenatal care, provided 6 or more visits are made after effective date of application;

\$32.50 for delivery and postpartum care; and \$5.00 for postpartum examination at 6 weeks following delivery.

For medical care of a sick infant, payment is made on the basis of \$2.00 per hospital visit and \$3.00 per home visit, with maximum limitations on any one illness. Payment is also made, in addition to fee for maternity care, for medical care of conditions *not* attributable to pregnancy but which occur during pregnancy or puerperium, also for major and minor non-obstetric surgical procedures, for consultation service and for travel.

Questions and Answers

At present only about 30 per cent of the physicians in Georgia are participating in the EMIC program. A number of Georgia hospitals do not accept EMIC cases, some because they do not meet the minimum requirements for standards of care and others because they do not wish to participate in the program. Wartime conditions and lack of understanding of the service are responsible for some of this non-participation. The more common questions posed are:

Why is the fee schedule not comparable to that in effect for private cases? This is a wartime program and fees were worked out by the Federal Agency. It was possible in July 1944 to get the original fee of \$40.00 for maternity care raised to \$50.00. Every effort has been made to inform the public that fees on this program are not comparable to those charged for private cases in many communities and that physicians accept EMIC cases because of their patriotic desire to help carry their share of the load.

Why is payment for maternal care delayed until services are completed? It is not possible to determine what payment would be due for services not yet rendered. For example, \$5.00 is deducted from the physician's fee when postpartum examination is not done as this examination is considered a routine part of maternity care.

Are all these forms necessary? Filling out forms is a vexing necessity but keeping up with federal funds entails record keeping. The forms have been simplified as much as possible.

Can consultants be utilized? Yes. Provision for consultation service is made in such a manner that the attending physician is not subject to any loss of payment provided he does not relinquish the case. The attending physician notifies the State Department of Health when a consultant is called in order that such service can be authorized.

What about diagnostic service? The attending physician can avail himself of diagnostic procedures, such as x-ray, laboratory tests, etc., provided facility used offers acceptable service and will accept payment according to EMIC fee schedule. Payment for hospital care includes diagnostic procedures, therefore in-patients are automatically provided with such service.

Why do some hospitals refuse admittance to EMIC cases? It is the privilege of both hospitals and physicians to refuse participation in the EMIC program. Many hospitals are wrestling with over-crowded conditions and shortage of personnel and feel they cannot accept additional patients. Some do not agree with the EMIC method of determining payment. The majority of participating hospitals are paid actual cost per patient per day, based upon their financial statement covering a 12-month experience, such mode of payment being based upon the recommendation of experienced hospital administrators. Other hospitals do not measure up to the very minimum requirements established for hospital facilities under the program. Minimum standards are indispensable in the program if the public interest is to be safeguarded.

Accomplishments of the Program

Despite numerous faults and the need for further improvement, the EMIC program met and continues to meet the very real need for maternity and infant care for the dependents of military personnel. From the beginning of the service in September 1943 through Feb. 23, 1945, more than 11,800 cases have been authorized for care and out of this number some 6,468 babies have been delivered. Such accomplishment is made possible only through the cooperation of Georgia physicians and hospitals. The State Health Department wishes to take this opportunity to thank all those who have enabled the program to proceed, and to offer any assistance or information possible to both physicians and hospitals. The success of a service program is

dependent upon the cooperation of those rendering the service. Therefore, Georgia physicians and Georgia hospitals are due credit for the accomplishments of this emergency program.

EDWIN R. WATSON, M.D., *Director*.

Maternal and Child Health Division.

Georgia Department of Public Health.

NEWS ITEMS

The Clarke County Medical Society held its meeting at the Athens General Hospital, Athens, Jan. 19, 1945. Dr. Paul Beeson, Grady Hospital, Atlanta, was guest speaker and his subject was "Penicillin." The following officers were elected: Dr. Tom A. Dover, president; Dr. C. S. Lancey, vice-president; Dr. Loree Florence, secretary-treasurer; Dr. W. H. Cabaniss, censor; Dr. W. H. Gholston, delegate; and Dr. Tom A. Dover, alternate delegate.

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, Feb. 6, 1945. "Unusuals in Allergy" was the subject of the guest speaker, Dr. Mason I. Lowance, Atlanta.

Dr. James Hubert Milford, Hartwell, recently graduated from the Medical Field Service School, Carlisle Barracks, Pa., with the commission of 1st Lieutenant, Medical Corps, Army of the United States.

The Fulton County Medical Society held its regular meeting at the Academy of Medicine, Atlanta, Mar. 1, 1945, with the following scientific program: "Therapy of Tuberculosis," Dr. C. C. Aven; "Epidemiology of Tuberculosis," Dr. R. Floyd Payne; "Rehabilitation of the Tuberculosis Patient," Miss Frances Beery, National Tuberculosis Association; "The Hospital Authority," Mr. Thos. K. Glenn.

Dr. G. Lombard Kelly, Dean of the University of Georgia School of Medicine, Augusta, announces the addition of three faculty members. They are: Dr. W. H. Waller, associate professor of anatomy, who teaches gross anatomy and neuro-anatomy; Dr. Russell A. Hug-gins, assistant professor of pharmacology; and Dr. George P. Childs, a research fellow in pharmacology under a special grant.

The Baldwin County Medical Society, Milledgeville, held its meeting Feb. 21, 1945, with the following members present: Drs. Y. H. Yarbrough, J. I. Garrard, C. B. Fulghum, T. C. Cox, G. L. Echols, F. B. Mitchell, Sr., R. W. Bradford, W. A. Bostick, Z. S. Sikes. Dr. Marco Fernan-Nunez, new pathologist for the Milledgeville State Hospital, was also present. Dr. J. M. Anderson told about a mental defective diabetic patient who developed an acute otitis media and early lobar pneumonia and went into diabetic coma as a result. The patient was treated with penicillin with startling results. An interesting discussion pertaining to diabetes and its management followed. Dr. Marco Fernan-Nunez showed interesting films, showing numerous spirochetes under dark-field, also a film on "Tropical Disease in Spanish West Africa," revealing many interesting diseases. The following officers for 1945 were elected: Dr. Z. S. Sikes, president; Dr. G. L. Echols, vice-president; Dr. J. M. Anderson, secretary-treasurer; Dr. C. G. Cox, delegate; Dr. C. B. Fulghum, alternate delegate; Dr. R. W. Brad-

ford, Dr. W. A. Bostick, Dr. C. B. Fulghum, board of censors.

Dr. G. Lombard Kelly, University of Georgia School of Medicine, Augusta, and Dr. Y. H. Yarbrough, Milledgeville State Hospital, Milledgeville, have returned from Washington, D. C. A method of rotation whereby interns from the Medical School will serve the State Hospital, Milledgeville, and Tattnall Prison, Reidsville, was discussed with government officials.

Dr. M. J. Egan, Savannah, has been elected president of the Hospital Service Association of Savannah. The election took place at the annual meeting of the association which was held at St. Joseph's Hospital, and the other officers included: Dr. Lawrence Lee, vice-president; Dr. H. B. Cooledge, secretary, and Dr. John J. Cornell, treasurer.

The Social Hygiene Conference under the auspices of the American Social Hygiene Association, the United States Public Health Service, the Social Protection Section, Federal Security Agency; the Georgia Social Hygiene Council, and the Georgia Department of Public Health, met at the Biltmore Hotel, Atlanta, February 20. The theme was: "Social Hygiene—A Community Responsibility in War and Peace."

The Georgia Medical Society held its annual President's Meeting at the Savannah Hotel, Savannah, February 13. Members of the armed forces were especially invited.

The Bibb County Medical Society dinner meeting was held at the New Yorker Cafe, Macon, March 6. Dr. Lon Grove, Atlanta, was guest speaker and his subject was "Surgery of the Stomach and Duodenum."

The Georgia Baptist Hospital staff dinner meeting was held February 20 in the Nurses' Home dining room. Dr. C. E. Rushin, clinico-pathologic chairman, prepared for the professional meeting an interesting program.

The Southern Regional Conference of the Council on Medical Service and Public Relations met at the Academy of Medicine, Atlanta, February 23, with Dr. James E. Paullin presiding. Agenda: "Description of Creation and Program of Council," J. W. Holloway, Jr.; "Program of Washington Office," Joseph S. Lawrence; "Post-War Medical Education," Victor Johnson; "Bureau of Information," Harold C. Leuth; "Rehabilitation," Carl Peterson. After luncheon Senator Claude Pepper of Florida spoke on medical legislation.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton St., Savannah, February 27. Papers: "Continuous Caudal Analgesia"—Illustrated with a motion picture, Dr. James L. Southworth, U. S. Marine Hospital, Savannah; "Obstetrical Aspects of Continuous Caudal Analgesia," Dr. A. J. Kelley. Members of the armed forces were especially invited.

OBITUARY

Dr. William Andrew Borders, aged 78, Floyd County physician, died Jan. 15, 1945. Born in Murray County, he was educated in Gordon County schools, and was graduated from the Atlanta Medical College, now Emory University School of Medicine, Atlanta, in 1890. For 53

years he practiced medicine in Floyd and adjoining counties. Dr. Borders was a member of the Floyd County Medical Society, the Medical Association of Georgia, the Armuchee Methodist Church, and was a Mason. He is survived by his wife, Mrs. Nancy Elrod Borders; three sisters, Mrs. J. E. Strickland, Mrs. J. L. Reeves, Mrs. J. L. Reddick, all of Calhoun; four brothers, J. E. Borders, Miami, Fla.; E. C. Borders, LaFayette; H. E. Borders, Dalton, and A. M. Borders, Fort Valley. Funeral services were held at the Armuchee Methodist Church, with the Rev. J. R. Baxter and the Rev. J. B. Ward officiating. Interment in Adairsville Cemetery.

Dr. Thomas Parker Bullard, aged 74, died at his home in Palmetto Jan. 19, 1945. He was graduated from the Emory University School of Medicine, Atlanta, in 1897. Dr. Bullard was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the Palmetto Methodist Church. Survivors include his wife; two sisters, Mrs. F. R. Smith and Mrs. M. S. Herring, Palmetto, and two brothers, J. F. Bullard, Palmetto, and D. B. Bullard, Baltimore, Md. Funeral services were held at the Palmetto Methodist Church, with the Rev. C. F. Hughes officiating. Interment in Floral Hill Cemetery.

Dr. John Thomas Garland, aged 88, died at his home, 108 Burford Place, Macon, Feb. 18, 1945. He was born at Hillsboro, the son of the late John T. and Nancy King Garland. Dr. Garland was graduated from Vanderbilt School of Medicine, Nashville, Tenn., in 1878, and afterwards did postgraduate work at Bellevue Hospital in New York City. He was a typical country doctor, practicing for many years in Jasper County. He retired in 1918 and moved to Macon. Surviving are his wife, the former Miss Susan Beckham; five nephews, King, Howard and Rufus Garland, all of Hillsboro, and Gus and Will Garland; two nieces, Miss Mamie Wyness, Hillsboro, and Miss Nan Hunt, Macon.

Dr. James Henry Savage, aged 62, died at Crawford W. Long Memorial Hospital, Atlanta, Feb. 8, 1945. Born in Dawson, Dr. Savage was a graduate of Emory University School of Medicine, Atlanta, in 1915. He had practiced medicine in West End, Atlanta, for 35 years. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, and the Park Street Methodist Church. He is survived by his wife, the former Miss Elizabeth Manley; a daughter, Mrs. Clay Sybert, Atlanta; two sisters, Mrs. Irvin Gates, Tallahassee, Fla., and Mrs. A. N. Wallace, Atlanta; and a brother, Jack C. Savage, Atlanta. Funeral services were held at Spring Hill, with Dr. E. Nash Broyles officiating. Burial was in West View Cemetery.

Dr. James Edgar Woods, aged 77, 1056 Maryland Ave., N.E., Atlanta, died Feb. 3, 1945. He was a native of Henry County and was graduated from the Atlanta Medical College, now Emory University School of Medicine, Atlanta, in 1894. Dr. Woods took many postgraduate courses in leading medical schools, had a wide influence and left a heritage of unselfish service in serving suffering humanity. He was a member of the Medical

Association of Georgia, the American Medical Association, the Masonic Lodge, and the Associated Reform Presbyterian Church. Survivors include his widow, Mrs. Eva Bosworth Woods; a daughter, Mrs. Bruce Hafley, Atlanta; and a son, Captain Don Woods, U. S. Army, Ft. McPherson. Private funeral services were held with Dr. S. A. Tinkler officiating. Interment in West View Abbey.

ARMY MICROFILMS MEDICAL JOURNALS

The microfilming service of the Army Medical Library is keeping Army medical officers at remote installations in every theater of operation abreast of the latest published techniques and discoveries.

Starting with 12 medical journals in January, 1943, the list of periodicals microfilmed has grown to 44, covering the whole field of medicine. These are filmed immediately upon publication. Sent by airmail, military intelligence or diplomatic pouch, the rolls of film are in the hands of Medical Department personnel all over the world within 15 days.

In addition to the medical journals, unpublished manuscripts describing even more recent developments are also microfilmed, and upon request sent to our military medical personnel.

The microfilm process saves approximately 95 per cent of shipping space. One 100-foot roll, for example, holds about 1300 pages or from 12 to 14 journals. Whereas one roll of microfilm weighs about six ounces, the same amount of printed material would represent six pounds.

REDUCTION IN THE MEDICAL CORPS OF THE ARMY

A moderate reduction in numbers of Army Medical Corps officers is necessary in order to remain within presently allotted ceilings, the Office of The Surgeon General has announced. The need for Medical Corps Officers in senior grades who are assigned principally to administrative duties is less acute than formerly.

A board of officers recently appointed in the Office of The Surgeon General is carefully considering the physical and other qualifications of all Medical Corps officers of the various components of the Army and their essentiality to the war effort.

As a result of this board's study, it is anticipated that a number of separations of the above group will occur in the moderately near future. Regular Medical Corps officers will be accorded retirement privileges under the provisions of Section II, Ar. 605-245, June 17, 1941, and Reserve, National Guard, and AUS Medical Corps officers will be given the opportunity of returning to the practice of medicine in a civilian status by relief from active duty or discharge.

MATCH BOOKS CARRY HEALTH MESSAGES TO TROOPS

Match book covers are being used by the newly formed Health Education Unit, Preventive Medicine Service, Office of the Surgeon General, as one means of instructing our soldiers about louse powder, water purification, and the prevention of trench foot and dysentery.

UNITED NATIONAL CLOTHING COLLECTION

(Continued from Page 59)

committees in every community. And as April — the month of the active drive — approaches, the need for volunteer help in handling the contributed clothing; of cartons and boxes in which to pack it; of local receiving depot space, and trucks and other transportation facilities, will afford American business people a variety of ways in which they can extend most valuable service.

Participation in the community drive, special drives among employees, trades, industries and labor groups are being welcomed by the national committee.

All men and women are urged to contact their local United National Clothing Collection chairman or committee with a view of extending such aid to the drive.

TEACHING OF FOREIGN LANGUAGES

The claim that the teaching of foreign languages in our schools should not be started before the usual high school age should be reexamined, *The Journal of the American Medical Association* for January 20 says.

"After the war," *The Journal* explains, "scientific and medical discoveries will doubtless be made in what are now enemy countries and will be described in their own language and scientific periodicals. . . . The linguistic ability of most Americans compares unfavorably with that of Europeans and others who are exposed early in life to two or more languages. Many leaders

of educational opinion in this country have claimed that there is no good reason to teach foreign languages in the schools before the usual high school age. This claim should be reexamined. Medical science has never failed to recognize the need for widespread dissemination of new discoveries; a most important instrument is comprehension of the language in which the discovery is made. Support of any methods, therefore, by which a greater knowledge of foreign languages can be achieved in this country will deserve the support of the medical profession."

NEED NOW IS FOR 16,000 NURSES

The Army needs 16,000 additional nurses immediately in order to care adequately for wounded and sick American soldiers, according to Major General George F. Lull, Deputy Surgeon General.

During the first two weeks of February, 1,450 registered nurses received commissions as officers in the Army Nurse Corps. This is an increase over the 1,050 commissioned in January, but the total number of nurses is still far short of the Army's immediate needs.

With the flood of new patients from overseas, the authorized ceiling for the Corps was recently raised from 50,000 to 60,000. At present it numbers only 44,000 and about 250 nurses a month are separated from the Army for various reasons. About 71 per cent are overseas, some having been in foreign theaters for several years. Incidentally, a more effective rotation plan for these overworked nurses will be possible when the full quota of 60,000 is reached.

DIAGNOSIS AND SURGERY in DISEASES OF CHEST

Roentgenography, Fluoroscopy, Lipiodol
Bronchography, Bronchoscopy,
Esophagoscopy

Pneumothorax, Pneumolysis,
Thoracoplasty, Extrapleurals.

S. C. LYNN, M.D.

118 E. Jones St.

SAVANNAH, GA.

WANTED: One resident physician for Georgia State Tuberculosis Sanatorium, Alto, Georgia. Address inquiries to Dr. H. E. Crow, Medical Superintendent.

WANTED — Physicians for mental hospital; graduates class A school; experience in psychiatry desirable but not essential; salary and partial maintenance; near two excellent colleges. Address Box 325, Milledgeville, Georgia.



LONG LAST
Laboratory Tested

SURLES X-RAY CO.

Concentrated X-Ray Chemicals

34-11 56th Street Woodside, N. Y.

**FASTER - LONGER LIFE - RICHER BLACKS - CLEARER
WHITES - DOES NOT DROP OFF SUDDENLY**

The Medical Profession will find it easy to control the quality of films with LONG LAST tested chemicals. LONG LAST will save money with its LONG LASTING qualities. Its speed will save time. Your dealer will supply you. Insist on LONG LAST. Circulars upon request. Available in 1 and 5 gallon sizes.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, April, 1945

Number 4

COMBINED SURGICAL AND INJECTION TREATMENT OF VARICOSE VEINS

CHAS. E. RUSHIN, M.D.
Atlanta

The cause of varicose veins appears, as a rule, to be the result of back pressure transmitted from the intra-abdominal veins. Occupations which require long periods of standing put great pressure on the valves, causing them to give way and then varicosities develop. Heredity is also a predisposing factor. Patients frequently have poorly developed valves which cannot withstand the stress and strain put on them as adult life is reached. Pregnancy is also an etiologic factor. Many women have large varicosities during pregnancy which become much smaller after delivery, when the enlarged uterus returns to normal size. Thrombophlebitis involving the femoral and iliac veins often cause varicose veins. The superficial veins enlarge to take care of the venous circulation while the deep veins are occluded. When the deep circulation has been re-established, the walls and the valves of the superficial veins have been so severely damaged that they cannot take care of the normal flow of blood. Hence, a reverse flow develops.

There is a great increase in the number of people afflicted with varicose veins now because of the prolonged working hours required of civilians, and this is also true of those in the armed forces. Many middle-aged people, who under normal times would not do heavy work, are putting in long hours on the farm, as well as in the war plants.

Each patient that presents himself for treatment should have the following tests in order to decide the type of treatment indicated:

Trendelenburg Test

Berntsen classifies the phenomenon in three groups:

(a) Trendelenburg positive when the reverse flow from the deep veins takes place at the sapheno-femoral junction, or through one of the large communicating veins in the thigh.

(b) Trendelenburg negative when the back flow from the deep veins takes place through the incompetent communicating veins in the leg while the valves in the great saphenous in the thigh are competent.

(c) Trendelenburg nil. In this group there is neither a reverse flow through the sapheno-femoral junction nor through the communicating veins in the leg. The veins in this group have dilated walls, but the valve edges coapt and are competent, thus preventing backflow. This phenomenon represents an early stage in the development of varicose veins.

Cooper elicits the Trendelenburg test as follows: With the patient in the recumbent position, a series of tourniquets are applied from the groin downward. The patient then stands. If the varices are large, yet fill slowly, one may be certain there is no backflow from the deep veins. With the patient still standing, the tourniquets are removed, one at a time, from below upward. If the veins remain collapsed below any tourniquet, the reverse flow must take place at some point above. If the vein remains collapsed to the highest tourniquet, the only source of reverse flow must be from the femoral at the sapheno-femoral junction. This is called a Trendelenburg positive. If the veins fill suddenly and under great tension when the patient stands with the tourniquet on, it is classified as Trendelenburg negative. Trendelenburg double is when both positive and negative tests exist.

The comparative tourniquet test devised by Ochsner and Mahorner combines the ad-



Figure 1

Drawing showing the location of incision made for resection of the great saphenous vein at the sapheno-femoral junction.



Figure 3

Superficial fascia has been incised and the great saphenous vein has been tied with No. 3-0 Deknatel silk. Another ligature of a No. 3-0 Deknatel silk is being carried beneath the great saphenous vein with a ligature carrier preliminary to again ligating the vein.



Figure 2

The skin and subcutaneous fat have been excised, showing the superficial fascia.



Figure 4

The ligature of the proximal portion of the great saphenous vein is caught with a hemostat and is used as traction on the vein. Here the external superficial pudendal vein is being ligated.

vantages of the several other tests and, when fully interpreted, gives extensive information about the circulation of the veins in the lower extremities. The patient is observed standing, draped so that both thighs and legs can be seen. Walking to-and-fro will cause some reduction in size of the varicose veins, because the pumping action of the muscles will draw the blood from the superficial veins into the deep veins and aid in its return to the heart. The patient then stops walking and a tourniquet is applied to

the upper third of the thigh, and he walks to-and-fro again. It is then applied to the middle third of the thigh and the veins are observed, and last the tourniquet is applied to the lower third of the thigh and again the prominence of the veins is checked. The interpretation of the test is as follows: If a maximum improvement occurs when the tourniquet is at the highest level, and there is no further improvement when the tourniquet is at the middle or lower third of the

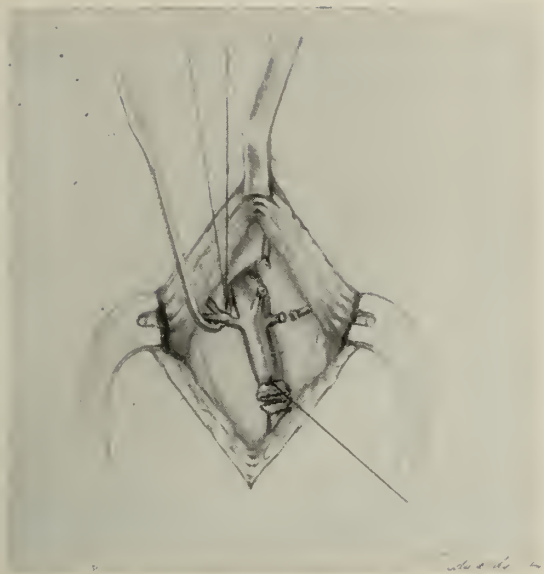


Figure 5

The external superficial pudendal and superficial epigastric veins have been ligated and severed and a ligature is being placed around the superficial circumflex iliac vein.



Figure 6

All of the tributaries have been ligated and severed and the great saphenous vein is being transfixied and ligated with No. 3-0 Deknatel silk. Another ligature is placed proximal to the transfixion ligature. Also a French-eye needle is used. This drawing shows the ordinary type of needle, and does not show the second ligature which is placed on the proximal end of the great saphenous vein.

thigh, then only one source of retrograde flow exists, and that source is from the femoral down the great saphenous vein. If there is greater improvement in the varicose veins below the tourniquet when the tourniquet is at the lower third of the thigh than when it is as the upper third of the thigh, it is evident that not only is there retrograde flow from the deep to the superficial system through the main opening of



Figure 7

This drawing shows the completed operation, and the wound is ready for closure.

the great saphenous vein, but there is also a leak through the communicating veins below the level of the fossa ovalis. The test depends on the condition of the varicosities below the tourniquet.

Perthes' test is similar to the Ochsner and Mahorner test, though only one tourniquet is used. This test was devised to determine the patency of the deep veins. The major arteries should be palpated to determine if there is an inadequate arterial blood supply. Intermittent claudication, lowered temperature of the skin and color changes are indications of disease of the arteries.

Contraindications for Surgery and Injection

Acute infections, hyperthyroidism, thromboangiitis obliterans, and marked arteriosclerosis of the arteries in the lower extremities.

Indications of Surgery

All varicosities should be operated on when there is a retrograde flow of blood from the deep to the superficial circulation. When the retrograde flow is from the femoral down the great saphenous, a complete resection of the great saphenous vein and all tributaries at the sapheno-femoral junction should be done. If there is a retrograde flow from the popliteal down the small saphenous vein, a resection at the sapheno-popliteal junction is indicated. Wherever

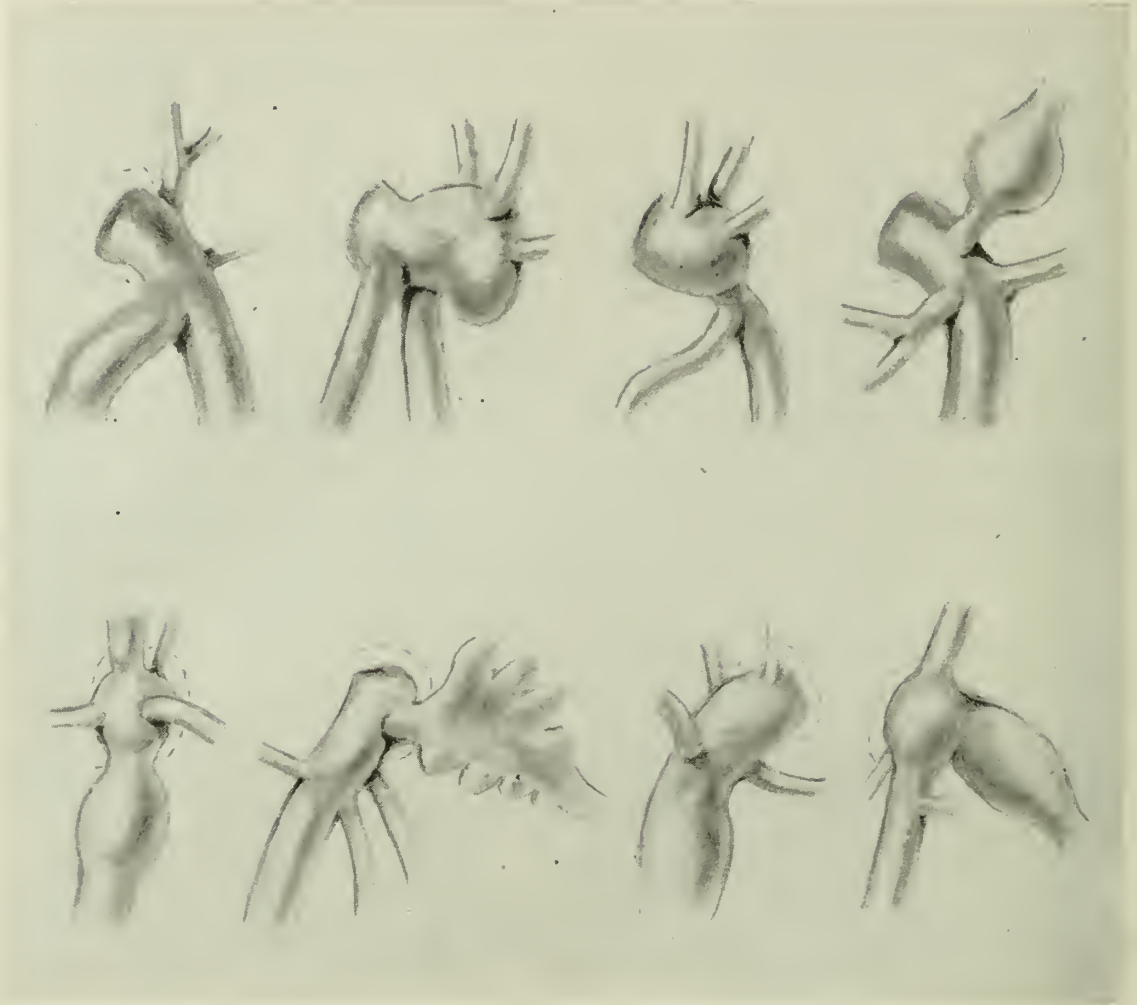


Figure 8

Here are sketched the many anomalous conditions seen. Some of these patients have sacculation of the tributaries, sacculatation of the great saphenous vein and in others there is a double saphenous.

there is a retrograde flow through any of the communicating veins, a resection should be done at that point. Failure to evaluate the various tests, and failure to do a thorough operation, followed by complete sclerosis of the varicosities, will only lead to poor results, and bring the treatment of varicose veins into disrepute.

Operative Technic

The patient is admitted to the hospital the evening before the operation is to be done. The lower abdomen and both inguinal regions are shaved and thoroughly scrubbed the same as for any abdominal surgical operation. Nembutal, grains $1\frac{1}{2}$, is given one hour before the operation, and $\frac{1}{6}$ grain of pantopon thirty minutes before operation. If the patient is allergic to opiates, the pantopon is omitted. If nausea develops post-operative, it is usually caused by the opiate.

After the skin has been painted with one of the mercurial preparations and the field draped, the femoral artery is palpated as it passes under the inguinal ligament. One finger-breadth internal to the femoral artery is the site chosen for making an intradermal wheal with 1 per cent procaine. A line is marked out, downward and slightly inward for $2\frac{1}{2}$ to $3\frac{1}{2}$ inches, depending upon the obesity of the patient. This area is infiltrated with 30 to 80 cc. of procaine. The needle is introduced into the skin as few times as possible in order to avoid infection. After the skin has been incised, the subcutaneous fat is separated with the fingers. The superficial fascia is then cut longitudinally, exposing another layer of fat. If the incision has been made in the proper place, the great saphenous vein will be easily found. Any lymph nodes encountered are pushed aside, and not removed. If

the nodes are enlarged, the great saphenous vein will lie beneath it. A self-retaining retractor is inserted. The great saphenous vein is stripped free of its sheath, ligated in two places, and cut between the ligatures. The distal end is released. The ligature on the proximal stump is held taught, and the sheath is stripped away. As each tributary is isolated, it is ligated and divided between the ligatures. After each tributary is cut, it makes it much easier to deliver the next tributary. The lower border of the fossa ovalis now comes into view. It is sometimes necessary to tie and cut the small artery here in order to ligate a small tributary at this point. The external and internal superficial femoral veins seldom empty into the saphenous vein this high, though it does occur. The external superficial pudendal, the superficial circumflex iliac, and the superficial epigastric, are the tributaries usually found at the sapheno-femoral junction. Two of these may anastomose and join the saphenous as one. There also may be double saphenous veins, and to omit ligating even one of these tributaries would only result in a prompt recurrence of the varicosities. Large sacculations of the great saphenous vein, or any of the tributaries make the operation more difficult. Even small unidentified tributaries, no larger than No. 1 catgut, are large enough to permit a reverse flow and cause a recurrence. The superficial epigastric vein is the one most difficult to locate. It is sometimes necessary to ligate the external superficial pudendal artery in order to uncover the vein.

After all of the tributaries have been ligated, the sheath is freed from the sapheno-femoral junction, and the great saphenous vein is ligated with No. 1 Deknatel silk. The vein is then transfixed with the same size silk, using a small French eye needle. The ligature is placed flush with the femoral vein, so as not to leave any sacculation which might be the source of an embolism.

The superficial fascia is closed with No. 0 plain catgut, and the skin is closed with small silk. A dressing is firmly applied to the wound, and then an Ace bandage is applied from the toes to the knee.

Wherever there is a reverse flow from the deep veins to the superficial veins, that segment of the varicose vein should be excised. When there is a positive Trendelenburg test in the small saphenous vein, a transverse incision is made over the sapheno-popliteal junction, and a resection is done the same as in the great saphenous vein. The small saphenous vein is transfixed and ligated as it passes through the deep fascia and joins the popliteal vein. Care should be taken to closely suture the superficial fascia to prevent herniation. The patient is required to walk immediately after the operation, and walk at least ten minutes of every hour. The next day he leaves the hospital, and is permitted to do light work.

RESECTIONS OF VARICOSE VEINS
TABLE 1

Total number of operations.....	826
Males	362
Females	464
Unilateral Resections	640
Right great saphenous.....	312
Left great saphenous.....	328
Bilateral resections	160
Sapheno-popliteal resections	25
Bilateral sapheno-popliteal and bilateral sapheno-femoral	1
TOTAL	326

RESECTIONS OF VARICOSE VEINS
TABLE 2

Average Age of Patients:	
Male	41 years
Female	37 years
Causes:	
Heredity	20 per cent
Thrombophlebitis	22 per cent
Occupation	30 per cent
Pregnancy	28 per cent

Retrograde injections are seldom given. Injections are given in the thigh first, and at each visit other injections are given at a lower level until all varicose veins are sclerosed. No attempt is made to use large doses in order to speed up the treatment. Extremely large doses of the sclerosing solution cause perivenanitis, marked induration and make the patient very ill.

Patients are required to wear Ace bandages for several weeks or until all of the varicose veins have been sclerosed, and all soreness has disappeared.

The recurrences have been less than 3 per cent in the past five years. Prior to this time recurrences were more frequent, because of failure to evaluate the various tests, or failure to locate all of the tributaries and ligate them.

I BECAME A PATIENT

T. C. DAVISON, M.D.
Atlanta

I have been ill several weeks and Dr. Shanks suggested that I write something, while "resting," on the subject of "The Doctor As A Patient." I can assure you the viewpoint as a patient is very different, when one is on the receiving end of the line. I was taught, while in the Army 28 years ago, that one should never give orders until he could also take orders from those higher up. To be a good patient one must take orders well.

Many volumes have been written on the doctor's attitude toward his patient, on the bedside manner, surgical judgment, etc., but little has been written on the attitude of the patient. Presumably the patient is always supposed to be a layman, with implicit confidence in the doctor's ability and, although his life may be at stake, he is expected to accept the verdict blindly, whatever the diagnosis and treatment may be. The doctor occupies a very peculiar position toward his patient: he is the prosecuting attorney, the jury and the judge. He presents the evidence, renders the verdict, passes the sentence, and then as sheriff proceeds to enforce the sentence. The patient, if he is not satisfied, has no recourse but to another doctor.

When, after a hard day's work, one suddenly finds himself sitting on the side of his bed with pain under the sternum, and extending down his left arm, and has some difficulty in getting a deep breath or has air hunger, and these symptoms do not respond to the remedies at hand but require a hypodermic, and these attacks recur at 24-hour intervals for several days, one realizes that he has ceased to be the doctor and has suddenly become the patient. Everything is in reverse: instead of giving orders he is now taking them.

The electrocardiogram reports are in, consultation is held and the verdict is: occlusion of a small branch of the coronary artery. Well, we should be thankful for *small* favors, yes thankful that they are no larger, and especially since several of my personal friends have suddenly passed on recently because of coronary occlusion.

Now, comes the sentence: five or six weeks in bed, several more weeks out of normal work and habits, and then work half-time for one year.

Nurse, please put my watch in the top dresser drawer, for I will not be needing it for a while. It is no longer a question of minutes and hours,

but just days and weeks for me now. I can now sympathize with the Negro prisoner in the Fulton County jail who, looking through the bars, called down to another Negro passing on the street and said: "Say, nigger, what time is it?" The reply was, "What fer you want to know, you ain't gwine nowhere."

Many times I have felt like spending a week in bed, but after a few days there the routine became rather monotonous. I probably shed a few silent tears in self-pity and then set about rearranging my daily schedule. For many months I had been getting up at six o'clock each morning, which is rather early in the winter time, and would be at the hospital by "sun up"; and didn't get home until dark or later, and frequently was called out at night.

I now have had a chance to really get acquainted with my family and to appreciate them more. Father's bedroom has become the upstairs sitting room and my children have become much more father conscious and more considerate and devoted. My wife, a graduate nurse, has appointed herself chief head nurse and general boss, and how she has enjoyed it, and so have I. She breezes into the room and announces: "Now I shall shave you, give you a bath and a rub-down, change your pajamas and put on fresh sheets." I was very comfortable and didn't want to be disturbed, and argued that my bed was all right and that I didn't need a bath. Yes, you have guessed it: I was shaved, bathed, powdered and perfumed and the bed changed, fresh pajamas, handkerchief in pocket, all before the doctor arrived. One day after this routine ordeal was over and I was propped up with a small satin pillow under my head to make reading easier, a neighbor, Mrs. M., came in. She looked at me and said: "Well, you look like a male hussy." I had a good laugh at the wife, and the head nurse, and left off a few of the extra frills after that.

I have often wondered what I would do if suddenly I became ill in a strange city and was at the mercy of strange doctors. I remember an incident which occurred several years ago while I was on duty at Grady Hospital. An aged transient was brought in with a strangulated hernia, and as the attending surgeon I was notified. I gave orders for the operating room to be set up, and the patient prepared at once for an operation. When I arrived the patient was in the operating room with several interns around him, and the anesthetist was ready. No one had realized that the patient was a stranger in a strange city. I made a hasty examination and assured him that everything would be all right, and then I noticed the frightened expression on his face. He held out his hand to me and gave the grip of a prominent secret order, and when I returned it he relaxed and closed his eyes, as tears streamed down his cheeks, and said that he was ready. Too often we are unable to see

the situation from the patient's standpoint and perhaps we are inclined to become impatient at times.

All of us have been called upon at times to treat a brother physician, or perhaps a member of his family, and so often the doctor patient cannot forget that now he has ceased to be the doctor and is only a patient and should act accordingly, but instead he insists upon prescribing for himself and refuses to obey orders, and still holds his doctor responsible for the results. Often I have heard nurses state that doctors are the worst patients in the world, and the hardest to nurse.

Being just up from several weeks illness and now convalescing, I have had considerable time on my hands to think things over. I have tried to be a good patient and obey the instructions of the doctors and the nurses, and have tried not to make suggestions. At first, while really ill, that was fairly easy; then came the weeks of just remaining in bed or serving out my sentence. One finds it hard to pass away the time, but gradually one learns to regulate his time schedule, beginning early in the morning by listening to the World News over the radio; breakfast is served while you listen to the breakfast clubs over radio, followed by reading the morning paper, then spending several hours reading the many books which friends have brought in, such as "The Emperor's Physician," "The Doctors Mayo," "The Autobiography of Irvin Cobb," "Canal Town" and others. Lunch is served, more reading, then comes the afternoon news by radio and the evening paper, then dinner and more reading, and finally the late news at 10:00 P.M. and lights out for the night.

I would watch through the east window for the sun to come up in the morning, then in the late afternoon gaze out the west window of my room as it dropped down behind the pine trees in the west, and the stars began to sprinkle the heavens. On one such day I was reminded of my good friend Dr. H., who several years ago, after being dangerously ill for weeks, finally began to improve and, just after the big ice storm we had at that time, he was shuffling down the corridor of the hospital on a beautiful sunlit day, when one of the interns passed him and said: "It's a beautiful day, Dr. H." My friend stopped and pointed his palsied finger at him and said: "Listen son, they are all beautiful to me."

When first allowed out of bed I would sit by the window and read and watch as the season slowly changed. The rains came, followed by sunshine, now the jonquils, daffodils, and narcissus are in bloom, the weeping willows down by the creek are budding rapidly, the red birds are singing in the dogwood on the lawn, and the white ducks are swimming in the little pond above the bridge. Winter has given way to spring in the few weeks I have been confined to my bedroom. Now I am allowed to walk out-

side on warm sunny days; the sun feels good and I just sit on the rocks down by the creek and soak up the sunshine. I am gradually regaining my strength, although I am still a little weak and shaky but feeling fine.

I am grateful to my doctors and my nurses and appreciate every attention and service. I am thankful to my many friends for the many cards and messages received and for the personal visits. There is a saying that flowers are sent to the beautiful, candy to the sweet and books to the literary. I have received many flowers, a lot of fruit, some candy and many books, all of which I greatly appreciated and have enjoyed. Above all I am thankful to God for my recovery. There is a short story from "Chins Up" by Mildred Seydell, which illustrates my opinion of faith in God. I believe He often uses the doctor, His wonders to perform — He is "my co-pilot."

According to the story, an old Negro — Uncle Lige — put his savings in a small and supposedly worthless piece of land, which had suffered from neglect and soil erosion and was covered with weeds. By hard work and loving care he developed it into a beautiful vegetable and flower garden. When everything was growing nicely Uncle Lige invited his preacher out to spend the day. After a hearty meal, the preacher looking through the cabin door said: "Lige, you and de Lawd done done yerselves proud. Dis sho is a purty place." The black owner scratched his head and replied, "Yassir, preacher, we sho has, but yer orte seed dis place when de Lawn was managin hit by hisself." Faith without work is useless. Robert Quillen said that happiness comes from within, and that there are three prerequisites for happiness: *health*, *companionship* and *work*. I hope to be reasonably healthy again within certain limitations, my companionship cannot be improved upon, and I hope to be able to work for suffering humanity, though perhaps somewhat limited, as long as I live. I shall never retire, certainly not willingly.

Everyone should have his or her will prepared while in health; mine was made several years ago and has been changed several times as conditions changed. During my illness, having time to think and talk, I have been inclined to discuss my business affairs with my wife, I may say over her protests. I told her that if and when my end came, I wanted an autopsy held, as I expected they would find, as I have often seen in similar cases, an ischemic area in the heart muscle as a result of the coronary occlusion. She informed me that in Georgia permission for an autopsy required the signature of the nearest living relative and that a man's body belongs to his wife and that there will be no autopsy. So now I shall never know; well, what difference does it make anyway, but I should liked to have known.

Now after eight weeks there is a little matter

of unfinished business awaiting me; yes, patients.

And though the day be cloudy and overcast, rainy or sunny; yes they are all beautiful to me.

HEART-VASCULAR AGING

EDWIN S. BYRD, M.D.

Atlanta

All hearts age as the individual advances in years, just as do all other tissues of the body. In many people the heart grows old slowly; in others, and this includes the great majority of us, the heart ages long before other organs or tissues show evidences of time. So-much-so is this statement true that it may be said at the present time, the person of sixty years is likely to die as a result of cardiovascular-renal disease in five or six times out of ten. It may be stated that even a child at birth will have fifty chances out of one hundred of dying as a result of cardiovascular-renal disease. In a human who has gone through the third decade of life, these chances are increased fifty-five per cent. The hypertensive person will expire as a result of cardiac failure or coronary occlusion in seventy per cent of instances. It is true that most of these deaths are directly vascular deaths. Actually heart disease, as a cause of death, exceeds all causes irrespective of age, sex, or race. It may be stated in time of a world war we all of us are about the same age — from eighteen to forty-five years.

The ever-increasing length of life makes heart or vascular disease a very real problem for the medical man. He has seen and will see a continuously augmented number of older patients who have begun to give subjective evidence of heart disease. As a matter of fact, in the next few years the specialty of geriatrics will be almost as important as is that of pediatrics. People live longer than they lived in the past, and this is due to the well-trained physician. He has been the initiator and worker in the field of pre-natal and post-natal care, in controlling epidemics of contagious disease, in the fight against tuberculosis, in the campaign to control syphilis. He has been responsible for more prompt and earlier diagnosis of disease and for studies which re-

sulted in reducing the death rate in diabetes, thyroid disease, in cancer. Presently he is the attentive student of new chemotherapeutic agents in infectious diseases. The death rates from pneumonia, meningitis, and streptococcic infections have, within the last few years, diminished with almost unbelievable speed. As a result of these health measures of varied and diverse character, the medical profession is now confronted with the problem of taking care of the older generation.

Of course, it is perfectly obvious that a person grows old because aging is an evolutionary process which proceeds with greater or lesser rapidity in various people. Basically, growing old rapidly or slowly lies in the arterial tree and yet we do not know why arteriosclerosis is an inevitable concomitant of aging, not why it proceeds and develops with alacrity in some people and with tardiness in others. Probably the most important factor is that of inheritance. Every physician knows the importance of heritage in the role of aging, but, unfortunately, we cannot pick our ancestors. The physician sees, repeatedly, families whose members are old when they are fifty years of age; of other families he knows members who, when passed three score and ten, are still young physically and psychically. The person who has a family tree which shows evidence of aging rapidly, usually has a habitus and psyche which are quite characteristic — a tendency to overweight, to have the hypersthenic body structure and to be mentally on the alert, going hard and driving all the time.

There are numerous other factors which are presumed to help all individuals grow old quickly. The person who does not have money enough to have ample and adequate diet, who lives in close contact with his neighbor, will probably not live as long as the one who is fortunate to have an income sufficient to do away with vicissitudes of poverty. Where a person lives undoubtedly plays an important role. Geographically, in the tropical and subtropical countries and in the far east, people live longer because they are not obliged to live a life of rapidity and bustle. The man who lives in the country does not have to work under the same

tension as does the man who lives in one of the big cities. All these statements have been proved statistically. Just why married life leads to longer life is a question. Figures show, however, that the married individual lives longer than his bachelor brother. Tobacco and alcohol play little part in growing old quickly, unless in excess. The calm, peaceful and placid person may grow very old. Excesses in life increase the blood pressure, put the arteries under repeated strains which eventually will result in fibrotic changes in the smaller blood vessels.

It hardly needs to be stressed that the past medical history is of great importance. The man with syphilis at the age of twenty years is not likely to survive the man who has been free of this infection. The child who has rheumatic fever usually dies young, though he may survive the acute attack. The person who contracts tuberculosis may die before his allotted time. Glandular diseases take their toll, especially the thyroid, adrenals and prostate.

It is a fact that different arteries in the body are biologically older than are others. The anterior descending branch of the coronary arteries matures sooner than any other artery of the body. It being the oldest vessel, it is easy to see why coronary disease is more likely to develop in it than is vascular disease elsewhere in the body of man.

The construction of the heart is totally unlike other tissue. It is a muscular organ which increases in size and weight as a person grows old, differing from other muscles in the body which waste during the process of aging. The heart-body-weight ratio decreases as the individual ages. As the heart grows older, its valves begin to lose their elasticity and pliability; they are likely to become rigid, notably so in the left heart. As time rolls on, the blood pressure gradually increases but normally; it does not attain figures higher than 150 to 160 systolic and 80 to 90 diastolic, as observed in a group of patients past seventy years of age. Usually, at the sixth decade of life, blood pressure figures are fixed, unless modified by endocrine disorders or vascular disease, and remain the same for the rest of a person's life. The heart rate immediately after normal birth is more rapid than at any other

time of life. Slowly the rate declines so that by the time a man attains the age of thirty-five, the rate is well established for the person and remains so for the next three decades where, again, it gradually diminishes to a rate approximately around 60 beats per minute. Mechanistic disturbances develop in the heart as it gets older, chiefly extrasystoles and ectopics, but heart block may occur, attacks of fibrillation may take place and certain electrocardiographic changes develop, notably left axis deviation, low voltage, sinus bradycardia and variations in the T waves in any or all leads.

Subjectively, sensations of the patient with beginning heart involvement are unquestionably the most definite evidences of failures in the efficiency of heart muscle.

Physical fatigue is an often overlooked symptom, which time and again has been talked about by cardiologists and yet frequently forgotten by most of them. A man with a worn-out heart will tire under physical activities which previously would not tire him. Anginal pain is another symptom of great importance and is, positively, an indication for cessation of the physical or mental work which brings it on.

Shortness of breath is of importance but not as an early symptom, nor is it as important as the symptom of easy to tire.

The occurrence of premature contractions causes more psychic worry than cardiac harm. The physical examination may show calcification of the costal cartilages rendering them more or less fixed. The development of old age emphysema makes it hard indeed to outline the heart by percussion and often diminution in the size of the heart is found which, when examined by x-ray, is actually found to be larger than the normal heart.

Accentuation of the aortic second sound makes its appearance in people past the age of forty-two, whereas those under the age of thirty have an accentuation of the pulmonic second sound.

The occurrence of systolic murmurs at the base or apex of the heart are of little diagnostic importance.

The examination of the peripheral blood vessels is of some moment but the blood vessels are deceptive, as degeneration of the

media, with atrophy of the muscular elements and frequent calcium deposits in the atrophied muscular cells may not produce high blood pressure or coronary vascular changes. It occurs in the muscular and not in the elastic arteries.

The care of the aged person is not always a simple procedure, as it is hard for some of them to practice self-preservation; the older person must slow down and minimize his physical activities, he must not drive himself, and he must be restrained to quietude and calmness. The doctor must caution the older man or woman. He or she must have ample rest and notably rest after meals when the splanchnic area is engaged. The coronary circulation is increased after eating and a large per cent of coronary accidents occur shortly after eating a large meal. Of course, it must be forcibly fixed in the mind of the patient who has angina or anginal discomfort that any physical or psychical effort that he makes which brings on the pain, should be discontinued and that this pain is a warning signal which must not be disregarded. The nightly rest in bed should not be longer than eight hours. The dynamics of the circulation, when a patient is in the supine position over a long period of time, are unfavorably altered so that eight hours in bed should be the maximum at any one time, the need for sleep being compensated by a nap after meals or in the middle of the day. In regard to rest, it should not be forgotten that both physical and psychical rest are very necessary. Emotional excitement should be avoided: anger is as harmful to the blood vessels as any other one thing. The man who is getting older should have some exercise, but it should not be the exercise that he has undergone or indulged in when he was younger. Prolonged auto trips, hard shooting expeditions and long golf games should be abolished and there should be substituted shorter trips, fishing or a few holes of golf. Retirement from active business is bad, unless a man has an avocation which can supplant his vocation. All doctors are familiar with the man who stops work and then disintegrates and degenerates with a rapidity which is almost unbelievable. The older

person should be advised to reduce his total food intake: not to worry about the quality of the food as much as the quantity.

To the older person alcohol in moderation is often beneficial. A highball or a drink before dinner is relaxing and enjoyable.

Drugs in the treatment of the aging heart are of some importance, but not maximum importance. There is very little reason in giving digitalis in small doses on the basis of the drug being a heart tonic. In the older person who develops pneumonia or who has upper respiratory infection which may develop into pneumonia, it is an excellent idea to start digitalis promptly. In the older person who may have signs of hyperthyroidism, digitalis is of great value. In this older person auricular fibrillation sooner or later is going to develop. Quinidine is very helpful in controlling ectopics. For the hypertensive person, sedatives are certainly of very distinct aid in controlling the nervous symptoms associated with this disorder.

Anginal pains that cannot be controlled by simply resting, demand nitroglycerine to control the symptoms. It is a question whether or not the xanthine derivatives, aminophyllin, theobromine and theocacium, which have a dilatory effect on the coronary vessels, should or should not be given continuously to the old person who shows evidence of coronary disease. A word of caution—morphine should be avoided, if possible, in the acute coronary attack. This drug sensitizes the vagus and increases coronary constriction. It should be replaced with papaverine, one or even two grain doses, if the pain is not too severe. Morphine should always be combined with atropine to counteract the effect of the former drug on the vagus nerve.

In conclusion, what I have said in the body of this treatise, I trust is obvious. The two most important observations I consider to be: first, the statements concerning the age of the coronary artery; secondly, the necessity of treating the arteriosclerotic heart patient with sympathy and with tact. To go slowly, stay on level ground, and ease

(Continued on page 85)

THE PRESIDENT'S PAGE

THE CHALLENGE OF THE FIELD ARMY OF THE AMERICAN CANCER SOCIETY

The medical profession has become more and more aware each year of the import and value of the work done by the Field Army of the American Society for the Control of Cancer. This lay group, consisting mostly of women, is just finishing its ninth annual drive which takes place every April. Papers and magazines of the nation have carried thousands of articles of sound information concerning the warning symptoms of cancer, and have helped dispel the damning ignorance, superstition and false pride that have delayed diagnosis or even professional investigation.

Though we acknowledge gratefully the value of this annual campaign, and give complete endorsement, our responsibility is a great deal broader than that: the challenge is definitely to know the entire program of the drive, and the allocation of all funds collected at this time.

The major objective of the Field Army has ever been the education of the public concerning the early symptoms of cancer, and the necessity of prompt treatment. This has been done by leaflets, editorials, radio, public talks, posters, and all other methods of propaganda.

The funds collected—never sufficient for

expenses until last year — did reach fair proportions at that time. The quota for each state, and of each county, is \$1.00 per hundred people, hence Georgia's quota is \$30,000. Thirty per cent of this is sent to the National Headquarters of the American Cancer Society. Of the 70 per cent which remains in each state 10 per cent is used to pay expenses of the organization; 40 per cent goes to the educational program and the remaining 50 per cent is used for relief of indigent cancer patients, being allocated to the several state projects by the committee responsible for the work.

But in spite of the nine years of organized work and propaganda, cancer is still the dread enemy of the white man; 18 die every hour in America of this disease. Science *must* find the answer to this great unknown question. The scourge must be checked. Hence, for the first time since the Field Army was organized as an auxiliary to the American Cancer Society, a financial objective has been set — \$5,000,000 is the amount needed to be used for research in this baffling disease. It is a definite challenge to us to encourage and contribute toward the consummation of this great scientific and humanitarian objective. To constantly see patients doomed to die who might have lived long lives of usefulness but for cancer, is challenge enough for our entire and enthusiastic support.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

APRIL, 1945

MEDICAL SUPPLIES: THEIR TRANSPORTATION

The long history of man's effort to conquer disease, subdue pain and fend off destructive plagues has added a dramatic chapter with the growing international traffic in medical, pharmaceutical and dental supplies via air express.

As the swiftest form of modern transportation, air express was afforded numerous instances in 1944 to prove its emergency value in rushing drugs and vital equipment to countries outside our borders. A number of significant instances have been compiled by the Air Express Division of Railway Express Agency and they follow:

In April 1944, Guatemala City was struck by typhus fever. Vital shipments of medicine and DDT insecticide, flown to the affected area from this country, helped check and turn back the progress of the disease.

Sometime ago a rancher in Guatemala received by air express enough antianthrax serum to save a large herd of cattle. About 10,000 cubic centimeters of the serum was sped from New Jersey, place of its manufacture, by domestic airline first and then via international air express to its destination.

September 1944 saw 125 cc. of hog cholera virus vaccine rushed to Haiti by plane as an emergency shipment. Requiring constant refrigeration, the extremely perishable cargo could not have withstood a slower trip by water. Later on in November, another rush shipment of vaccine was flown to Bolivia after several bubonic plague cases had been reported. Sufficient quantity of the vaccine was sent to immunize 300 persons.

European regions are also receiving quantities of drugs, hospital equipment and laboratory material by air express. Surgical instruments, x-ray tubes, whole blood and blood plasma form a substantial part of the international air traffic during the past few war years.

Recently, the American Red Cross air-expressed 5,000 tubes of penicillin to Geneva for treatment of American prisoners of war. The largest single shipment of drugs, forwarded by international air express last year, weighed 20,000 pounds and was flown to South America at the rate of three miles a minute.

Pest-destroying insects and white mice used for experimental purposes are continually riding the air lanes as express cargo. Department of Agriculture entomologists recently flew 2,000 parasitized codling moths to their colleagues at

Lima, Peru. California insectaries ship between 10 and 50 million insects by plane each year to various parts of the world.

Dental supplies are moving in ever-larger volume by air express. A gaucho who has lost his teeth wants his American plates in a hurry and generally calls for delivery by air. About 1,500 sets of the false teeth are flown each month by one airline to South and Central American countries, according to REA.

Not all the medical traffic flies out of the country. Numerous cases of emergency imports by air express are helping bind the northern and southern nations of the American continent together. A striking example was the parasitic invasion of the Florida sugar cane region last year which was brought under control by importation of Argentine toads. The toads, which feed on sugar parasites, reached Florida by plane on time, to save much of the crop. Similarly, a shipment of insect eggs was flown to the Cotton Belt as a preventive measure against the cotton-leaf worm.

PHYSICALLY HANDICAPPED WORKER EFFICIENT WHEN GIVEN JOB FOR WHICH HE IS SUITED

Industry is urged to continue after the war its present practice of utilizing physically handicapped men and women in jobs for which they are suited, in a report by Dr. Jack Masur, Acting Chief Medical Officer of the Federal Office of Vocational Rehabilitation, published by the National Society for the Prevention of Blindness.

"In order to secure for disabled persons their full share of opportunity within their capacity for normal employment ordinarily available in the labor market," said Dr. Masur, "we should continue to encourage the good will which now exists among employers toward persons handicapped by disablement. Most important is the necessity for a sustained public relations program to inform employers, labor unions, legislators, and the general public that vocational rehabilitation can fit a disabled person to the job successfully by means of physical restoration, vocational guidance, and training.

"Employers need to be reassured that under suitable conditions disabled persons can serve effectively without hazard to themselves or others. An excellent example of this type of publicity is the published declaration of attitude by the Association of Casualty and Surety Executives which encourages member companies to promote the employment of disabled persons. The report of the casualty and surety executives reminds employers that surveys have shown that physically handicapped workers are good workers; there is evidence that their absenteeism and labor turn-over records are strikingly better than those of the able-bodied; they have fewer accidents; they are conscientious, superior workers;

they expect no favors and they produce as well or better than the average of normal people."

Special attention must be devoted to visual protection of all handicapped persons so that their difficulties will not be compounded, Dr. Masur points out. Citing recent studies of the National Society for the Prevention of Blindness which indicated that industry overlooks the importance of visual conditions, even in plants that have good general safety practices, he emphasizes the necessity for the selection and placement of workers in accordance with an understanding of their eyesight. "A survey of 50 plants employing 166,682 workers," he said, "revealed that only 10 per cent reported they had performed job analyses for visual requirements; less than a third of the plants offered visual examinations; and only 14 per cent provided periodic eye examinations.

"In reports of accidents to safety departments only 22 per cent included a report on the eye condition of the person involved and only 12 per cent made reference to illumination at the site of the accident. The latter points are particularly interesting since it is believed that at least one out of every four accidents in industry is related to faulty vision or poor illumination. The survey indicated that approximately 70 per cent fitted safety glasses to their workers, but there was little evidence to show educational efforts through unions and supervisors or enforcement through mandatory regulations by management—significant because it is known that 98 per cent of accidents to eyes can be prevented through adequate safety measures.

"The war crisis emphasized the importance of sound industrial hygiene practices for the conservation of vision. There was a vast number of new workers unaccustomed to modern machine tools; there was an increasing use of older workers with diminished vision; there was widespread utilization of chemicals incidental to the manufacture of war products. All of these factors stressed the need for action.

"The demands of the war effort made it imperative that every worker be hired, that production be increased to the maximum, and that spoilage be reduced to a minimum. It was apparent that there was a great salvage of potential manpower possible in a well organized industrial ophthalmological program. There was need to recognize more generally that when a job needed vision, the man could work only as well as he could see.

"There are more than 300,000 industrial eye accidents in the United States annually, of which 60,000 are compensable. These figures are even more striking if we realize that approximately 1,000 workers lose the sight of one eye and approximately 100 workers lose the sight of both eyes each year. Since the National Society for the Prevention of Blindness is by its very name dedicated to preventing blindness, which is the

king of terrors for the workman, it is altogether appropriate that it lead the way in stimulating the interest of management, labor, government, and ophthalmologists in the extension of sight saving programs in industry."

DEFERMENT OF PREMEDICAL AND PRE-DENTAL STUDENTS

Dr. Victor Johnson, Secretary, Council on Medical Education and Hospitals, in his testimony before a Congressional committee on the Hill-Burton hospital construction bill, succinctly described the situation that will develop unless Congress acts promptly. He said:

"The present policies of governmental agencies regarding the supply of medical students is such that we shall be faced with a drastic reduction in the number of physicians after the war. Today the lack of provision for the training of doctors is such that we may anticipate that many hospitals constructed under this bill, if it is passed, will have no physicians to man them.

"In 1944 Army and Navy students entering our medical schools constituted 80 per cent of the entering classes. Twenty per cent were selected from civilian sources. It was becoming increasingly difficult for admissions committees to secure even this small percentage of qualified civilians from the sources available. In the year 1945 only about 53 per cent of the entering students will be Army or Navy students, increasing to 47 per cent the numbers which must be obtained from civilian sources. In 1946 there will be no Army students, and only approximately 10 per cent of the entering freshmen will do so under the Navy auspices. This increases those to be obtained from civilian sources to 90 per cent of the entering classes. One of two consequences is inevitable. Either the students will be of far poorer quality or they will be far fewer in number. We cannot afford either alternative. It will be impossible to obtain these large numbers of students from the category of men under 17, physically disqualified men, veterans and women. At the present time there is an utterly inadequate number of qualified individuals entering premedical training."

TEACHING GUIDE FOR HOME NURSE CLASSES

Teaching Guides to assist instructors of high school and college courses in Red Cross Home Nursing are now being prepared by the American Red Cross to be ready this fall. Providing specific suggestions for class discussions, demonstrations, and practice, the material is so arranged that the course may be adapted, with or without credit, to existing curricula. The course may be taught entirely by a nurse-instructor or in cooperation with instructors of other courses in the same general field.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

"Under ordinary peacetime conditions every county auxiliary in the State would be making plans to attend the annual meeting of the Auxiliary to the Medical Association of Georgia, usually held in May. But this is no ordinary year! These days are the most turbulent the medical profession and the auxiliary have ever known.

Following the precedent of the past twenty years of holding an annual meeting to review our work as an auxiliary, this would be a convention call. This year there will be no convention and our messages will have to be limited and carried on through correspondence. For the first time we will have to begin a new year's work without the inspiration gained and friendships renewed through meeting together. Many issues will come up that will be of vital concern to the medical profession and to the auxiliary. It will be necessary to keep informed on all these matters that will affect the nation's health. Read your medical journal, *Hygeia* magazine and *National Bulletin* for valuable information, and keep up with auxiliary happenings through the monthly column in the *Atlanta Constitution*. These same sources of information will furnish excellent program material.

"Ours is the supreme task of sponsoring and promoting health programs and acting as a liaison between the public and the medical profession. Much has been accomplished in recent years but there is much more to be done."

'Let us then be up and doing,
With a heart for any fate
Still achieving, still pursuing
Learn to labor and to wait.'

EVELYN PATRICK RANDOLPH, *President*.

The Woman's Auxiliary to the Baldwin County Medical Society held its March meeting at the home of Mrs. W. A. Bostick, with Mrs. George Echols co-hostess. Reports from the standing committees were given. The nominating committee submitted the following names for 1945-46 officers:

President—Mrs. Sam Anderson

Vice-President—Mrs. Edwin Allen

Secretary—Mrs. E. Y. Walker

Treasurer—Mrs. Charles Fulghum

Mrs. J. I. Garrard told of plans for Doctors' Day, March 30. A contribution was given to the Red

Cross drive. Miss Rose Thompson spoke on frozen food products, also about the organization of Grey Ladies. The Auxiliary will sponsor this movement.

Mrs. W. C. Hafford and Mrs. Bert Malone were hostesses recently to the Ware County Medical Society, which met at the home of Mrs. Hafford on Riverside Drive in Waycross. Dr. J. D. Stillwell gave a very instructive and interesting address on steps being taken in Georgia to meet the postwar needs in public health. A plan of expansion proposed by the Health Panel of the Agricultural and Industrial Development Board which has been, in the main, approved by the state legislature, was outlined and explained by Dr. Stillwell. The speaker also pointed out that even during the emergency Georgia has made much progress in public health as verified by the number of fine health center buildings erected since the start of the war, and the sharp decline of hookworm cases among the children of rural areas in the past five years. Georgia has every reason to be proud of her public health system which ranks among the highest in the nation.

The treasurer, Mrs. J. R. Gay, reported having purchased the second \$25.00 war bond for the Auxiliary. Members voted to subscribe \$7.00 to the Red Cross drive.

As the guests assembled for the meeting the hostesses served attractive refreshments.

The Woman's Auxiliary to the Richmond County Medical Society held a recent meeting at the home of Mrs. G. Lombard Kelly with Mrs. A. P. Briggs and Mrs. L. N. Todd as co-hostesses. The annual Jane Todd Crawford memorial program was presented. The speaker was Lt. Abeinda De Augiar, from the neuropsychiatric department of Oliver General Hospital. A report was given of a recent study course planned and outlined by Mrs. Claude Tessier and Mrs. Ralph Chaney in cooperation with a committee from the P.-T. A organization. About 40 women attended this course which lasted for four days. Mrs. J. W. Thurmond is president of the Woman's Auxiliary to the Richmond County Medical Society.

Mrs. W. T. Randolph and Mrs. Alex Russell, of Winder, were honor guests at the recent meeting of the Auxiliary to the Bibb County Medical Society, at the home of Mrs. Ralph Newton with Mrs. W. W. Baxley as co-hostess. Mrs. Randolph

(Continued on page 85)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACKson 7979.

SERVICE ABOVE SELF: THE PRIVATE DUTY NURSE

MRS. LUCILLE C. MURPHY, R.N.

*Vice-Chairman, Private Duty Section G.S.N.A.
Albany*

Have you ever thought that there were too many artists? Not just a person who can sketch off a rough sketch or finish a creditable water-color, but a true artist—one who can create a masterpiece! Have you ever thought that there were too many private duty nurses? These, too, are artists, artists who use their special skills and talents in helping suffering humanity. A hundred years ago the learned Scottish educator and author, William Blaikie, summed up for us the difference between the competent worker and the true artist when he said: "The highest art is always the most religious, and the greatest artist is always a devout man—A scoffing Raphael, or an irreverent Michael Angelo is not conceivable." There are, of course, some few reasonably competent private duty nurses who attend the chores of the sickroom without any sense of dedication. They go through their routine dutifully, but cheat themselves of the secret lift of the spirit which is given to those who have taken as their standard, service before self. But the majority of the women who have chosen the work of caring for the sick are women of greater heart.

In such times as these all private duty nurses are being tested. Each comes face to face with her conscience. She is being appraised by the public as never before. Is she doing only essential nursing? Is she carrying her part of the load in teaching? In recruitment? Is she willing to assist in public health work? Is she alert to and informed on governmental policies? Her conscience alone must guide her. But, tested as she is, her performance now marks her—for all to see—as a woman of quality.

As the private duty nurse pauses to study her immediate problems, she turns to look back at the road behind. The long hours, the poor pay, the lack of adequate educational facilities, the lack of prestige, the lay-offs in which her savings vanished, the dread of illness from overwork—these all added up to rough going. She now sees

ahead a brighter vista: better educational opportunities through scholarships and loans, greater strength and added prestige through the organization of her group, fees raised so that she may carry insurance against the days of illness, shorter hours, which will insure better health and allow her greater participation in professional and community activities.

And she stands there and breathes a deep and grateful prayer of thanks to those who trod that rough road before her. To those who had the vision to work for an organization that would give her her better chance. And this private duty nurse of today knows that she must add her weight to this organization. That an occasional meeting of her coworkers, called together for a chicken patty supper, is not enough. That being swayed by some spellbinder from a lecture bureau is not enough. That the avoidance of a controversy—rather than the grit to fight through and straighten things out—is not enough.

She realizes that a joint purpose and a rededication to the highest ideals of her profession are the answers to her problems—and the only answers. With clearer eyes now she looks around her. She sees deeply into the eyes of others. She sees the vacuous and frustrated expressions in the eyes of those who devote themselves exclusively to personal interest and pleasure. She views those not with criticism, but with pity, proud of her special talent. For it took talent to become proficient in her profession, it took three years of work and study; and she had to have "something on the ball" to make the grade. And she repeats again Emerson's wise words, "Talent for talent's sake is a bauble and a show. Talent working with joy in the cause of universal truth lifts its possessor to new power as a benefactor."

Now she sets her course, straight and true toward a better world ahead. She sees so clearly that the influence of the National Private Duty Organization will increase or diminish in exact ratio to the combined influence which the local and state private duty organizations can exert, and to the prestige which these enjoy in their own communities. She sees that she can become an active and effective agent in helping to shape

(Continued on page 85)

GEORGIA DEPARTMENT OF PUBLIC HEALTHT. F. ABERCROMBIE, M.D., *Director***FOOD-BORNE EPIDEMICS**

The seal of the American Public Health Association carries the inscription "and the leaves of the tree were for the healing of the nations." Abundant good food may be likened to these leaves. The strength or weakness of any nation is the cumulative strength or weakness of its individual citizens. Strong, healthy citizens are the product of the foods they eat.

Selective Service physical examinations have shown that our physical fitness is much less than is to be desired and much less than is possible. An analysis of Selective Service physical examination findings through September 1941 show a rejection rate of 52.8 per cent for various physical, mental and educational disabilities. The analysis of later examinations after the standards had been lowered, the age limits changed, and the greater urgency of military needs, still showed a rejection rate of 42.0 per cent.

Not all these rejections were due to inadequate diet, but malnutrition plus hidden hunger certainly was a factor in many instances. Henry Wallace at the National Nutrition Conference in 1941 said this: "When we consider the inadequacy of their meals, it is not surprising that 40 per cent of the young men examined for military service are being rejected because of physical disability. Not all of these rejections are for dietary deficiencies. Perhaps the examining officers would say that only a small percentage was of this nature, and yet I am convinced that it would be possible to take the men rejected and by good care and proper food, put perhaps half of them in condition to be accepted. Moreover, proper feeding in childhood for the other half would have enabled a high percentage of them to pass the physical examination. Probably a larger number of people today are being fed properly in the United States than ever before in our history, but we have just started to do a real job. We want to see that good food is "health plus, nor merely to 10 per cent of our people but to everyone."

The urgency of this problem has been well recognized. The accelerating nutrition programs of national, state, and local organizations, both public and private, are reaching our school children, industrial employees, and citizens in all walks of life.

In our national war emergency, food sanitation has had difficulty in keeping pace with the rapid development of feeding projects. Investigations of numerous food poisoning outbreaks or outbreaks of enteric infections resulting from contaminated foods, involving many hundreds of people in Georgia during the past year, have called our attention forcibly to the urgent need for better control of food sanitation. Anyone

who handles food or plans meals, even though his first interest is the provision of a balanced nutritious diet, cannot escape the responsibility for sanitary safety. Food handling and the imperative necessity for sanitation are inseparable.

Outbreaks of food poisoning have been investigated in industrial feeding establishments, in schools and colleges, along bakery routes, among customers of a local grocery store who bought contaminated home cured meat, and the like. There is no doubt that many other unreported outbreaks have occurred. The patrons of restaurants, cafeterias and other commercial eating establishments are frequently so widely scattered within two to five hours after eating (the incubation period for staphylococcus enterotoxin poisoning), or six to twenty-four hours or longer (the incubation period for ordinary food-borne enteric infections) that extensive outbreaks can occur without recognition of the common causative factor, and even without the knowledge of the responsible parties. The many hundreds of man-days lost to Georgia's war production effort because of known outbreaks which have been investigated could undoubtedly be multiplied many times if the facts concerning the undiscovered outbreaks were known.

The investigations of reported outbreaks have uncovered as the most frequent causes the poor personal hygiene of food handlers and the improper, insanitary preparation, handling or refrigeration of foods. The cause can usually be found on the premises where the food was prepared or served.

Every outbreak of food poisoning is preventable. Every outbreak is an object lesson. Something valuable can be learned from each study which is made. For example, in one of Georgia's largest industries which maintains its own feeding establishment, suspected food poisoning was reported to us in July 1944. Investigation revealed that complaints had been coming in in increasing numbers for sometime, but this was the first outbreak of the season where a number of acutely ill individuals all reported simultaneously. Eight individuals who had eaten freshly cooked, hot sliced ham became violently ill two to five hours later. It was shown that the hot ham had been sliced with a power-operated saw. The saw had not been cleaned since previous use and had particles of old meat clinging to the blade, housing, shaft, etc. It was easy for particles to be detached from the saw and cling to the sliced ham. Bacteriologic examination of such particles showed heavy contamination with hemolytic staphylococcus aureus.

Before the investigation was completed another more extensive outbreak had occurred involving 43 known cases within five hours after eating the

noon meal. These 43 individuals were the only cases reporting to the medical department for gastro-intestinal upsets during this five-hour period; 41 of the 43 had eaten a cold plate containing ham salad. Their symptoms were typical of enterotoxic poisoning. About 4,000 cold plates with the ham salad had been served at that meal; 41 cases of food poisoning occurred in less than five hours among the 4,000 who ate the cold plate, while only two cases occurred among the 9,000 other customers who did not eat the cold plate. This is too great a difference to have occurred by chance. It would appear that something on the cold plate was responsible for the food poisoning.

Hemolytic staphylococcus aureus was grown from samples of the ham salad on the cold plate, and from samples of old meat collected from the blades of the meat chopper. Food handlers were found with staphylococcus lesions such as an infected cut finger, acne, and nasopharyngitis.

About 4,000 ate the ham salad; 41 became ill; 3,959 did not. Why?

The ham had been chopped up in the power-driven meat chopper not over one and one-half to three hours before it had been served. Undoubtedly particles of old meat dropped off the blades and other parts of the machine and became scattered through the mixture as little islands. The salad was eaten before the staphylococci in these islands had time to propagate themselves and their enterotoxin throughout. But it would appear that certain helpings from the salad contained these islands of staphylococci, while other helpings did not. If this is a true picture of what happened, then the 41 cases which became ill must have eaten helpings which were so contaminated, while the 3,959 who did not become ill ate helpings which did not contain the little islands of contamination. But think what would have happened if the salad had been incubated at room temperature for several hours before serving. Staphylococci and enterotoxin would then have been disseminated throughout and many hundreds of cases would have been anticipated.

The lesson from all this is the necessity for strict food handling sanitation. It concerns everyone who prepares or consumes food as well as everything used in the preparation of food for human consumption. To help reduce the incidence of food poisoning in Georgia the State Department of Health in June 1944, assisted by the U. S. Public Health Service, started schools for food handlers in cooperation with the local health departments. These schools were soon coordinated with the restaurant training program of the State Department of Distributive Education. By the end of the year, schools had been held in ten cities and in two industrial plants plus some fifty-seven follow up classes, plus continuous inplant training by management of the industries.

The school program is adjusted to meet the individual needs of the locality, type eating places and type people to be trained. The usual schedule includes an elementary study of bacteria, showing actual growth of bacteria by demonstration; information on such common pests as flies, rats, and roaches and how to prevent and control them, and a review of the care and storage of food and use of equipment. Emphasis is placed on the food handler's responsibility to know more about sanitation and to apply sanitary procedures in doing his job. True-false tests are used to show information received. Demonstration and group participation are used to make training more effective. Motion picture films and lantern slides emphasize particular points.

Are you a physician who is treating cases of food poisoning? Are you a manager in charge of an eating establishment, either hotel, restaurant, cafe, cafeteria, tearoom, snack stand, or other? Are you an employee of such an establishment? Or are you merely a person who eats out and notices the need for such a training program? If so, contact your health department or department of education, and inquire as to the possibilities of a food handlers school for the establishment you have in mind.

L. M. PETRIE, M.D., *Director,*
Industrial Hygiene Service,
Georgia Department of Public Health.

POSTWAR CONTROL OF VENEREAL DISEASES

The postwar period will present far greater assets for the control of the venereal diseases than have been available at any previous time, Lieutenant Colonel Thomas H. Sternberg and Captain Granville W. Larimore, Medical Corps, Army of the United States, predict in *The Journal of the American Medical Association* for January 27.

"A tremendous number of physicians and lay personnel trained and experienced by the Army in the principles of venereal disease control," they say, "will be available. The dilution of the postwar population by 9,000,000 soldiers will raise the general venereal disease educational level to a new high, and it seems certain that future venereal disease control programs will be accorded increased public support. In this connection, efforts to reimpose a blackout on the venereal diseases are doomed to failure. The remarkable advances in treatment climaxed by the introduction of penicillin will add great impetus toward achieving the goal of universal case finding and case holding. Mass wartime experiences will add considerably to the venereal disease control armamentarium.

"These factors, added to the stabilization of community life and the return of opportunity to follow the natural instincts of monogamous relationships, all lead to the conclusion that we shall be presented with an unprecedented opportunity to reduce the incidence of the venereal diseases to a manageable minimum."

NEWS ITEMS

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, Mar. 20, 1945. Program: Major R. M. Robbins in charge. Motion picture—*Modern Nutrition*.

Dr. W. P. Durham, Atlanta, is taking a post-graduate course at the Cook County Hospital, Chicago, Ill., before moving his offices to the Doctors Building, Eastman, as an eye, ear, nose and throat specialist.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton St., Savannah, Mar. 13, 1945. Papers: "Typhus Fever," Col. Paul K. French, Hunter Field; "Infectious Mononucleosis," Captain John Franklin, Hunter Field. Members of the armed forces were invited.

Grady Hospital, Atlanta, has appointed its first women doctors to the resident staff. They are Dr. Sarah A. Taylor, Charlotte, N. C., a graduate of the University of Maryland Medical School, and Dr. Gertrude C. Luther, Madison, Wis., who received her M.D. degree at the University of Wisconsin. Both will be assigned to pediatrics.

The Georgia Baptist Hospital, Atlanta, staff dinner meeting was held March 20 in the Nurses' Home dining room. Dr. Mason I. Lowance was in charge of the program.

The Second District Medical Society met at Albany on April 12. Titles of papers on the scientific program were: "The Technic of Thyroidectomy with Emphasis on the Routine Exposure of the Recurrent Laryngeal Nerves," Dr. Phil E. Roberson, Albany; "Medicine," Dr. C. K. Sharp, Arlington; "Pediatrics," Dr. Helen Bellhouse, Thomasville. A representative from E. R. Squibb & Sons presented a motion picture on "Modern Nutrition and the Recognition of Diet Deficiency." The officers are: President, Dr. A. B. Jones, Quitman; Vice-President, Dr. L. L. Lundy, Boston; Secretary-Treasurer, Dr. J. C. Brim, Pelham.

The Seventh District Medical Society held its meeting at the City Hall, Dalton, April 4. Scientific papers: "Peptic Ulcer—Review of Present Day Treatment," Dr. Robert F. Norton, Rome; discussions led by Major Ed. Marshall, Battey General Hospital, Rome, and Dr. Fred Simonton, Chickamauga. "Bed-side Diagnosis of Common Cardiac Disorders," Lt. Col. S. M. Salley, Battey General Hospital, Rome; discussions led by Captain Dan L. Urschel, Battey General Hospital, Rome, and Dr. Grace Ross, Cedartown; "Discussion of Angiomata and Pigmented Nevi," Dr. Lee Bivings, Atlanta; discussions led by Dr. R. W. Fowler, Marietta, and Dr. J. E. Billings, Calhoun; "Magnetic Removal of Foreign Bodies From the Food and Air Passages," Dr. Murdock Equen, Atlanta; discussions led by Dr. Inman Smith, Rome, and Dr. Trammell Starr, Dalton. Officers of the Seventh District are: President, Dr. William Harbin, Rome; President-elect, Dr. F. H. Simonton, Chickamauga; Secretary-Treasurer, Dr. W. C. Mitchell, Smyrna. Committee on arrangements: Dr. Chas. F. Engleking, chairman; Dr. H. J. Ault, and Dr. W. E. Brown, all of Dalton.

The Woman's Auxiliary to the Seventh District Medical Society met April 4. Program: Welcome by Mrs. Trammell Starr, Dalton; Response by Mrs. W. C. Mitchell, Cobb County Auxiliary; Reading of Minutes; Reports from County Auxiliaries; New Business; Installation of New Officers; Address by Mrs. W. T. Randolph, Winder, President Woman's Auxiliary to the Medical Association of Georgia. Officers: District Manager, Mrs. J. E. Billings, Calhoun; District Secretary, Mrs. Murl Hagood, Marietta.

The Thomas County Medical Society met at the Archbold Memorial Hospital, Thomasville, March 21, with the staff meeting. Titles of papers on the scientific program were: "Malignancy of Kidney," by Dr. Rudolph Bell; Discussion on *Public Health Programs*—local—The report of Brill's disease. *State*—The status of care of patients with tuberculosis and mental disease. The group drew up resolutions for Judge H. W. Hopkins of Thomasville who died recently at his home. Judge Hopkins was a friend and adviser of Mr. John F. Archbold who gave the John D. Archbold Memorial Hospital as a memorial to his father in 1925. He served as president of the trustees of the hospital and his versatility and genius and his labors have made a lasting impression on communal life. His friendship with the donor was considered a factor in having the hospital given to Thomasville. The nursing situation is being surveyed. A committee of nurses and physicians will give a detailed report with recommendations.

A drug addict, middle-aged man, dark complexion, black hair, brown eyes, stoop-shouldered, weight about 150 pounds, right postoperative kidney scar, goes under the name of Stein but he may have other aliases, is an imposter and should be reported to the police or narcotic department. He is a good actor and malingerer, his chief complaint being severe right renal colic, with a history of previous operations on the right kidney. He is wanted by the police on other charges.

Dr. Rufus Floyd Payne, assistant Fulton County health officer, has been appointed medical superintendent of the State Tuberculosis Sanatorium at Alto. Dr. T. F. Abercrombie, state director of public health, said Dr. Payne will have complete charge at the sanatorium.

Emory University School of Medicine, Atlanta, will hold a one-day post-graduate clinic May 3, to which all members of the Fulton County Medical Society and physicians from over the State are invited.

The Fulton County Medical Society met at the Academy of Medicine, Atlanta, April 5. Scientific program: "The Control of Stature" by Dr. Jas K. Fancher; discussions led by Dr. T. Luther Byrd and Dr. Joseph C. Massee; "Ligation of the Inferior Vena Cava" by Surgical Department of Grady Hospital.

Dr. Harry Parks, Atlanta, is taking a post-graduate course in cardiology at the College of Physicians and Surgeons, Columbia University, New York City, which is sponsored by the American College of Physicians.

Dr. Murdock Equen, Atlanta ear, nose and throat specialist, who last year designed a magnet which removes metallic foreign bodies from the stomach and lungs, has been awarded the Thomas A. Edison Founda-

tion gold medal for outstanding achievement and contribution to the arts and sciences of 1944.

Dr. Millard E. Winchester, Brunswick, is receiving recognition for the fine work he is doing against the spread of disease in Glynn, Camden and McIntosh counties. He is fighting typhus fever, venereal disease, malaria and typhoid.

Major Lovick W. Pierce, Waycross, has been promoted to Lieutenant Colonel. Lt. Col. Pierce is executive officer of the 113th General Hospital at Khorramshahr, Iran, where he has served with the Medical Corps of the U. S. Army since 1943.

OBITUARY

Dr. Lee D. Stephens, aged 63, Sycamore, well known Turner County and South Georgia physician, died Feb. 12, 1945. He was born at Canton and was educated in the schools of Cherokee County and received his medical degree from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1912. In 1919 he moved to Sycamore and become one of the town's leading citizens. Dr. Stephens served on the Board of Trustees of the Sycamore School and on the Sycamore City Council. He was a member of the Turner County Medical Society, the Medical Association of Georgia, the Lions Club, Masons, Shrine, and the Sycamore Baptist Church.

Surviving are his wife, Mrs. Mary Jane Harbin Stephens, and the following children: Roy Stephens, Tifton; Mrs. Hewlett Adair, Jacksonville, Fla.; Mrs. Jones Lanneau, Nashville; Cpl. Hubert Stephens, Dublin; Cpl. J. Allen Stephens, Thomasville; Mrs. Stacy Morgan, Gava, Ill.; Prof. Carlton Stephens, Ashburn; Herbert Stephens and Helen Stephens, Sycamore; three sisters, two brothers, and eight grandchildren.

Funeral services were held at the Sycamore Baptist Church with the pastor, Rev. Pope Hulett, in charge of the services, assisted by Rev. W. T. Bodenhammer, Norman Park, and Rev. J. C. Moore, Pearson, former pastors.

HEART-VASCULAR AGING

(Continued from page 76)

aside worry is a great asset. A good book or magazine, a tree and clear brook with some fishing tackle, and a faithful dog, add greatly to peacefulness, quietude, and tranquility. Happiness and simple thinking are far better than climbing hills or stairs. We will win the war, and then the many boards and taxes will have to be run by the younger generation. So we must stand by and do the best we can, trust in God, eat what we can get, and pray for those who run our nation and give them all our support, remembering that common sense is the most scientific thing in the world and that selfishness, jealousy, and envy are the backbone of dishonesty. Fortunately, a person needs less as age begins to appear.

COMMUNICATION

To the Secretaries of Constituent State and Territorial Medical Associations:

It was intended that a meeting of the House of Delegates of the American Medical Association should be held in Chicago late in May or sometime during the month of June.

After conference with official representatives of the Office of Defense Transportation in Washington, I am quite convinced that permission to hold a meeting at that time can not be had. I was advised to file an application for permission to hold a meeting of the House, to agree that attendance should be held to a minimum and to hold the meeting much later than originally contemplated.

A letter is going forward to all members of the House of Delegates whose names and addresses are available so that they may be informed that the 1945 meeting of the House must be deferred.

As soon as necessary arrangements can be made an announcement concerning the time and place of the meeting of the House of Delegates will appear in The Journal and all secretaries of constituent state and territorial medical associations will be informed by telegram or by letter.

OLIN WEST, M.D.

Secretary and General Manager
American Medical Association,
Chicago, March 27, 1945.

AUXILIARY NEWS

(Continued from page 80)

spoke of various phases of the State Auxiliary work, urging the promotion of *Hygeia* magazine, also the sponsoring of the National Fitness Program as the Auxiliary can represent the medical profession in promoting it. She spoke of the effect of war on medicine, particularly of social diseases among adolescents, and suggested carefully handled sex education as a remedy, urging the Auxiliary to take the initiative.

After the program Mrs. Baxley and Mrs. Newton served tea.

SERVICE ABOVE SELF: THE PRIVATE DUTY NURSE

(Continued from page 81)

a world in which she will want to live, in dignity and usefulness. She whispers the Chinese prayer, "Lord, make this a better world and begin with me."

Poised, shining eyes facing a future unafraid, she tells herself that there will never be too many private duty nurses, private duty nurses who place service above self, private duty nurses whom vision and performance have transformed into artists.

URGES EARLY DIAGNOSIS OF CANCER

Spurred by a rising rate of 165,000 deaths, and 700,000 sufferers annually, Upjohn is assisting in the fight against cancer. With a message of hope which will reach millions during April when the American Cancer

Committee's national drive swings into action, Upjohn includes this major health problem in its "Your Doctor Speaks" series directed toward better public health and greater patient-physician cooperation. Since the greatest promise of reduction in cancer mortality lies in early diagnosis and treatment, the message stresses the importance of learning to "recognize warning signs of cancer *before* it's too late," and bluntly tells the reader, "You can help—by learning to suspect cancer and to report it at once."

Number five in a new series, the Upjohn cancer message, scheduled to appear in *Saturday Evening Post*, April 7; *Time*, April 16; and *Hygeia*, May, brings hope to millions of readers right from the headline—"You'd never guess he had a cancer five years ago." Beneath the figure of a distinguished middle-aged man painted in full color by a nationally famous artist, the message reads: "Yes, he's only one of the 90,000 who could be saved every year if cancer were reported in time. Today radium, x-ray, and surgery make it possible to control 70 to 80 per cent of early cancer, and about 39,000 cures have been officially recorded."

Special emphasis is placed upon an immediate visit to the doctor for a check-up at the slightest suspicion of cancer. A summary of possible signs of the disease is given, based on information from cancer authorities. "Faithfully follow your doctor's advice," urges the message. "If you have a beginning cancer, he can detect it, treat it, save your life."

Members of the medical profession, cancer organizations, and public health agencies who reviewed the message prior to publication commended the optimistic, encouraging tone of the text. A leading cancer authority terms it "constructive, far-seeing, attractive, and effective. The thing that makes a real impression on me is the positive approach to cancer, as well as the use of a cheerful and specific appeal."

COMMUNICATION

Dr. Edgar D. Shanks,
478 Peachtree Street, N. E.
Atlanta, Georgia
Dear Dr. Shanks:

I note in THE JOURNAL that you requested reprints and abstracts of articles which have been published in other journals. I take pleasure in sending you a copy of our paper "Incidence of Typhoid Fever in a Population Exposed to a Contaminated Industrial Water Supply," which was published in the December issue of

Industrial Medicine.

A study was made of an industrial mill village population exposed to risks of water-borne typhoid fever. Stool specimens were obtained from all individuals living or working in the village, with a few exceptions. Evidence is presented as to frequency of mild as well as asymptomatic cases of typhoid infection in exposed individuals. Search of the literature has revealed a dearth of evidence of this nature. This point, therefore, should be of interest to all physicians, since the evidence indicates that even during an epidemic at least one-third to one-half of all clinical infections escaped recognition. Industrial physicians should be particularly interested, especially those connected with industries which own or operate their own water supply or sewage disposal system. The "horrible example" given here shows the result of indifference to adequate, sanitary supervision and control of water and sewage. Even in this day and age, industries must still maintain eternal vigilance against breaking the fundamental laws of sanitation.

Sincerely yours,

L. M. PETRIE, M.D., *Director*
Industrial Hygiene Service
Division of Preventable Diseases
Georgia Department of Public Health.

The first issue of *Westinghouse Newsfront*, a new monthly publication by the Westinghouse Electric and Manufacturing Company, will appear in April.

The four-page report, printed in two colors and illustrated with drawings and photographs, will contain short articles describing the latest achievements by the company in the fields of scientific research, engineering and production.

DIAGNOSIS AND SURGERY in DISEASES OF CHEST

Roentgenography, Fluoroscopy, Lipiodol
Bronchography, Bronchoscopy,
Esophagoscopy

Pneumothorax, Pneumolysis,
Thoracoplasty, Extrapleurals.

S. C. LYNN, M.D.

118 E. Jones St. SAVANNAH, GA.



LONG LAST
Laboratory Tested

SURLES X-RAY CO.

Concentrated X-Ray Chemicals

34-11 56th Street Woodside, N. Y.

**FASTER - LONGER LIFE - RICHER BLACKS - CLEARER
WHITES - DOES NOT DROP OFF SUDDENLY**

The Medical Profession will find it easy to control the quality of films with LONG LAST tested chemicals. LONG LAST will save money with its LONG LASTING qualities. Its speed will save time. Your dealer will supply you. Insist on LONG LAST. Circulars upon request. Available in 1 and 5 gallon sizes.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, May, 1945

Number 5

SARCOIDOSIS

*An incidental finding in the postmortem
examination of an 81 year old woman
dying of coronary occlusion*

CARTER SMITH, Lt. Col., M.C.,
Army of the United States
H. CLIFF SAULS, M.D.
Atlanta

Sarcoidosis is a generalized disease of unproven cause but characterized pathologically by epithelioid tubercles with or without giant cells, with or without marked fibrosis and slight or totally absent cellular response other than epithelioid proliferation. Necrosis and caseation are usually absent.

In recent reviews of the literature^{1, 2, 3, 4} it was found that only 49 cases with post-mortem findings have been reported. This paper is for the purpose of adding an additional autopsied case to the literature.

Clinically, the disease bears many names: lupus pernio, osteitis multiplex cystoides, benign lymphogranulomatosis, uveoparotid fever and Besnier-Boeck-Schaumann's syndrome. The clinical manifestations are even more varied than the diagnostic terms applied to this disease. It may affect almost any tissue in the body but those structures more commonly involved were recently summarized in a study of 35 cases by David Reisner² and were as follows:

Lymph nodes, peripheral.....	35
Lymph nodes, intrathoracic.....	30
Lungs	33
Skin	14
Bones	9
Spleen	8
Liver	6
Eyes	7
Mucous membranes	4

Parotid gland	4
Lacrimal gland	2
Heart	2
Nervous system	2
Serous membranes	2
Breast	2

In a review of 26 autopsied cases, Rubin and Pinner¹ found the following clinical syndromes manifested:

Uveoparotid fever	2
Sarcoidosis of the skin.....	10
Osteitis multiplex cystoides.....	4
Benign lymphogranulomatosis	6
Atypical forms of disseminated tuberculosis.....	2
Localizations in the pituitary gland, adrenals, heart and diaphragm.....	2

Longcope, Fisher and Murphy⁴ report 6 patients with sarcoidosis involving the myocardium and pericardium. Arrhythmias were common and one individual had bundle branch block. It is of interest that the patient reported by us had bundle branch block and frequent extrasystoles, but this was associated with coronary arteriosclerosis and coronary occlusion rather than sarcoidosis.

Hilus adenopathy is often of such extent as to simulate the lymphoblastomas or other neoplastic disease of the mediastinal lymph nodes and lungs. This will occasionally require considerable diagnostic acumen for correct differentiation. Radiation therapy for sarcoidosis should probably be avoided, while such therapy for Hodgkin's and allied diseases would be indicated.

From the above it can be seen that the clinical picture encountered varies widely and will depend entirely on the tissues and systems of the body that are primarily involved.

Chronicity with a relatively benign course is usual. Benignity of the disease is probably overemphasized, for in a review of the cases¹ that have come to autopsy more than half of the patients died as a direct consequence of the disease, if caseating tuberculosis is accepted as one of the natural

developments of the disease. Whether or not caseation is one of the natural developments of sarcoidosis or is due to secondary infection with acid-fast organisms is not yet clear.

The disease is more common in negroes and in females of the second, third and fourth decades of life. It has been reported in an infant as young as three weeks of age¹ and in an adult 70 years of age². Our patient was 81 and is the oldest yet recorded.

The duration of the disease is variable and difficult to determine. In recently reported reviews,^{1,2} clinical courses ranged from six weeks to twenty-two years. It is difficult to estimate the duration of the disease in our patient as no symptoms occurring during the sixteen years she was under observation can be directly attributed to sarcoidosis.

REPORT OF CASE

E. B. H., a white female, was under observation from age 65 in 1926 to age 81 in 1942. The family history was negative except for two brothers who died of nephritis at ages 40 and 67 years. The patient's past history was irrelevant. Her average weight was 170 pounds.

In 1922 (age 61) she first noticed slight edema of the feet and ankles. By 1926 the edema had become more severe and she was examined at this time by one of us. There was moderate arteriosclerosis, slight left ventricular hypertrophy but no murmurs and the blood pressure was 195 mm. systolic, and 95 mm. diastolic. The lungs were clear, the liver's edge was barely palpable and the spleen was not felt. Laboratory and x-ray studies were normal other than a one plus albuminuria. Symptomatic therapy was instituted and the clinical course was uneventful for the next five years.

In 1932 she first noticed palpitation of the heart on exertion, and there was still a one plus edema of the feet and ankles and the blood pressure was 190 mm. systolic and 110 mm. diastolic. The first heart sound was definitely slurred at this time.

In 1933 the patient developed diabetes mellitus of moderate severity. This was controlled by diet and 30 units of insulin daily. During this 7 year period there had been a loss of weight from 170 to 115 pounds. In 1933 a diastolic gallop rhythm was first detected.

In 1934 anginal pain was first experienced and there were frequent ventricular premature beats. Blood pressure levels ranged between 145 mm. systolic, and 80 mm. and 100 mm. diastolic. During this year she also complained of considerable soreness and pain about the waist at the level of the costal borders. This pain was worse at night and was relieved by food. X-rays of the spine, gallbladder, gastro-intestinal tract and chest were normal except for hypertrophic arthritis of the thoracic spine, and after several months this complaint disappeared.

In 1937 a grade 2 apical systolic murmur was first heard. There was a persistence of the diastolic gallop rhythm. Anginal pain was more frequent and severe. During this year she developed an eczema that persisted recurrently until death.

In 1938 there was a severe attack of bronchitis which necessitated hospitalization (sarcoidosis of respiratory tract?). X-ray of chest at this time did not reveal hilar adenopathy. The patient's vision was now becoming impaired because of bilateral cataracts (no evidence of sarcoid uveitis). In late 1938, a second hospitalization was necessary because of severe precordial pain. Transient nodal rhythm was found at that time and the QRS width in the electrocardiogram had increased to the proportions of a bundle branch block but there was no definite evidence of a myocardial infarct. Recovery from this illness was uneventful.

During 1939, 1940 and 1941, there was a gradual increase in frequency and severity of the anginal attacks, bronchitis and eczema. In November 1941, she experienced a very severe anginal attack but there was still no definite electrocardiographic evidence of coronary occlusion. It was now necessary for the patient to remain continuously in bed because of decreasing cardiac reserve and increasing frequency and severity of anginal pain. On March 21, 1942, she was admitted to the hospital because of an attack of severe precordial pain and circulatory shock. The electrocardiogram showed an increase in the degree of bundle branch block but no evidence of recent coronary occlusion. With the administration of oxygen and opiates, the patient became quite comfortable and regained circulatory competence. Five days later, March 26, 1942, she died quietly while asleep.

Significant Autopsy Findings

Gastro-intestinal Tract: The liver was much larger than normal and weighed 1800 grams. The edges were blunt. Sections made through it revealed evidence of passive congestion. The gallbladder was large and contained one dozen faceted greenish calculi, ranging between 6 and 10 mm. in thickness. The pancreas was embedded in fat. It was normally lobulated and presented no unusual gross features. The gastric and duodenal mucosa were not ulcerated or scarred. The thoracic and abdominal portions of the esophagus were normal. The entire small and large intestines were devoid of scars or ulcers. They presented no constrictions or other signs of recent or old disease, except in the large intestine where there were a few apparently symptomless and harmless diverticulae scattered from one end to the other. Some of these contained hard fecal balls. The lymph glands of the mesentery were normal in size but those retroperitoneal glands were enlarged and measured 1.5 to 3 cm. They were firm and pale. The rectum and anus were grossly normal. The spleen was large and weighed 150 grams. It contained considerable blood but did not seem abnormal in any other respects. The adrenal glands were normal.

Genito-urinary System: The kidneys were normal size and weighed 110 grams. The capsule stripped with difficulty and the surface was granular. There was some atrophy of the renal cortex and it was less than one-fourth the total thickness of the parenchyma. The glomeruli

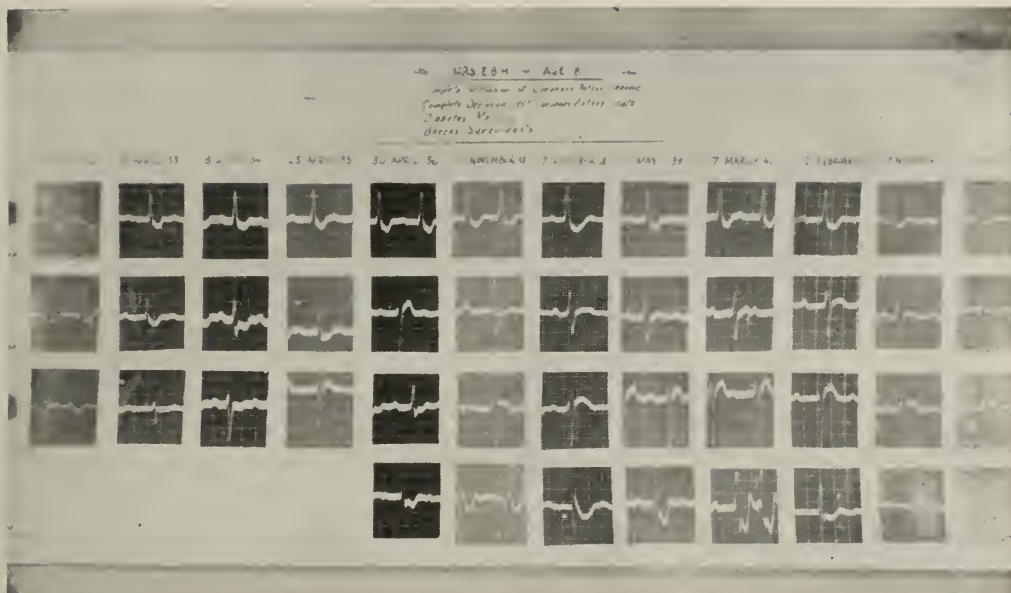


FIGURE 1

Serial electrocardiograms over a period of ten years showed the T waves of lead 1 remained inverted in all tracings. The T waves of lead 2 were inverted during 1932, 1933 and 1934 but became upright in 1935 and remained so until death. The T wave of lead 3 shows a similar shift of direction. Left axis deviation developed in 1933 and remained until death. QRS width gradually increased to 0.12 of a second. The ST

take-offs of lead 4 in 1939 and 1940 are the only deviations from the normal take-off in the entire series. First degree auriculoventricular block was seen in the tracings of 1940 and 1941. Runs of nodal tachycardia appeared in the record of March 1940.

Lead 3 of the tracing of April 30, 1936, is mounted upside down.

Examination of the arteries of the abdomen revealed a remarkable degree of arteriosclerosis. Atheromatous plaques were seen in the intima. No occlusions of any of the abdominal vessels were seen.

Lungs: Each pleural cavity contained 500 cc. of slightly blood tinged fluid which did not clot. The lungs were congested and edematous. Gross section through the lungs showed irregular firmness and soft solidifications of the posterior portions of the lower lobes. There was no evidence of parenchymatous tuberculosis or neoplasm. The pulmonary arteries contained only postmortem thrombi and liquid blood. There was calcification of the hilar glands, probably indicating old healed tuberculosis. The lymph glands of the mediastinum, particularly around the trachea, leading up into the neck were unusually and peculiarly enlarged. They varied from 3-5 cm. in diameter. They were pale and cut sections were friable. There were no enlarged glands in the neck above the thorax.

Heart: The heart was greatly enlarged. The pericardium was loosely adherent and could easily be dissected away from the heart. There was no pericardial fluid. The left ventricle was tremendously hypertrophied and moderately dilated. The right side of the heart was relatively dilated. The empty heart weighed, after fixation in formaldehyde, 570 grams. The fat on the surface was considerably thicker than usual. The coronary arteries were not visible externally. They were palpable, however, as twisted, tortuous hard pipe-stem vessels.

There were no antemortem clots in the heart. The valves presented evidence of arteriosclerosis with age. All of them were somewhat fibrotic. There was calcification of the mitral and aortic valves around the edges of the cusps. However, all cusps of the valves appeared to have been capable of good function since they met easily and since they had free, rather pliable edges. All of the valve rings appeared to be of normal size. The left ventricular wall measured between 1.5-2 cm. in thickness. The right, 1-1.5 cm. in thickness. Cross sections made through the middle of the ventricle showed marked scarring of the septum and of the left ventricle near the septum anteriorly. No recent infarcts of the heart muscle were noted. The scarring of the septum extended from the upper portion to the tip. This was represented as diffuse white hard strands of fibrous tissue. The left and right coronary artery ostia were patent. There was an old complete occlusion of the right coronary artery about 2 cm. distal to the origin of this artery. Here the lumen was completely closed with old scar tissue. Beyond this point the lumen was patent and contained blood. The circumflex branch of the left coronary artery presented a recent occlusion with fresh clot in the lumen about 2 cm. from its origin. All the coronary arteries presented a most remarkable sclerosis, with thickening of the walls and narrowing of the lumens. The sclerosis was not uniform, being thick in some places and thin in others. The aorta was slightly dilated. Numerous atheromatous plaques were seen. The aorta had lost a great deal of its elasticity. There was no evidence of syphilis. No antemortem clots were found in the pulmonary artery or any of its branches.

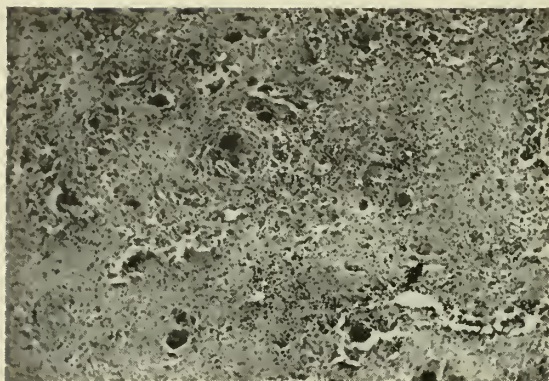


FIGURE 2a

Microphotographs of hilus and retroperitoneal lymph nodes show marked proliferation of the epithelioid cells. In some areas there is suggestive tubercle formation. There are many giant cells with more than the usual number of nuclei with an arrangement atypical to that of the usual Langhan's giant cell. There is no caseation.

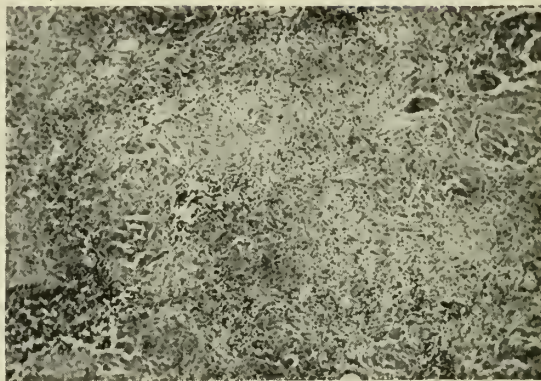


FIGURE 2b

There are fewer giant cells in this section than in figure 2a and less tendency to concentric arrangement of the epithelioid cells. Epithelioid proliferation is prominent and there is no caseation.

Microscopic Findings

Liver: The normal pattern of the liver was retained. It showed very marked cloudy swelling with its sinusoids filled with albumin. There was no evidence of passive congestion in spite of the patient's long history of heart failure.

Pancreas: Sections of the pancreas revealed no unusual findings. There was slight fatty infiltration of this organ.

Spleen: The spleen was very acutely and severely congested. The lymph follicles were definite in their architecture and general appearance. They were essentially normal. The arterioles had narrow lumina because of hyaline degeneration of the intima.

Lungs: The lungs presented no evidence of pneumonia. There were occasional small foci containing numerous giant cells, a few epithelial cells and very little fibrous tissue. These foci were not caseous. They were not typical of tuberculosis. They were probably part of the same process in the lymph glands to be described below. The bronchial lymph glands were surrounded by lymphocytes and some of them contained pus.

Lymph glands: Several sections were made from mediastinal and retroperitoneal lymph glands showed a peculiar granulomatous lesion. The lymph tissue was replaced with dense fibrous tissue containing much collagen. The lymph follicles had practically disappeared. Scattered throughout the collagenous matrix there were numerous giant cells and foci of infection, simulating those described in the lungs. The giant cells were of the tuberculous type. A number of epithelial cells were present and a relatively few lymphocytes. There was no caseation seen. The lesions were typical of those seen in Boeck's sarcoid.

Heart: Two sections were taken from the left ventricle; one from the septum; one from the lateral wall. Sections revealed a marked diffuse hypertrophy of the myocardium. The cells were large. In addition to this, there was a severe diffuse scarring. The scarring was most noticeable near the endocardium and consisted of avascular thick scar tissue with no evidence of infection. In addition to the localized scar there was diffuse fine scarring around the blood vessels.

Coronary arteries: A section through the occluded right coronary artery showed an old fibrous and atheromatous occlusion with irregular calcification. The tissue was relatively avascular. Section through the left circumflex artery revealed a recent antemortem thrombosis. Section through the descending branch of the left coronary artery revealed atheromatosis with lumen narrowing but no actual occlusion.

Comment

This 81 year old female patient was observed for sixteen years. During this time the following were her clinical diagnoses:

1. Hypertension.
2. Diabetes mellitus.
3. Arteriosclerosis.
4. Angina pectoris, coronary insufficiency with multiple myocardial infarcts, the last causing death.
5. Eczema, chronic.
6. Bronchitis, recurring, acute and chronic.
7. Hypertrophic arthritis of the lumbar vertebrae.
8. Cataracts, bilateral senile.

Postmortem examination confirmed the above diagnoses and added the following:

1. Sarcoidosis of the lungs, hilus and mesenteric lymph nodes.
2. Cholelithiasis.

In an attempt to determine how much of this patient's clinical picture, as it occurred over the sixteen year period of observation, may have been due to sarcoidosis, the following may be said:

1. Hypertension.
2. Arteriosclerosis.
3. Diabetes mellitus.

4. Hypertrophic arthritis.

These entities should have no etiologic connection with sarcoidosis.

Bronchitis, recurring, acute and chronic, may well have been a clinical manifestation of sarcoidosis as this is often a clinical manifestation of the disease. *Myocardial infarcts* are sometimes seen as a result of Boeck's sarcoid, but in this patient sufficient coronary arteriosclerosis was present to account for repeated myocardial infarcts.

Chronic eczema was in all probability not a part of the clinical picture of sarcoidosis even though skin lesions are frequently encountered in this disease. The character of the skin lesions of Boeck's sarcoid is not easily confused with chronic eczema.

Bilateral cataracts were in all probability a result of senile changes in this patient and not a part of the sarcoid syndrome. The eye lesion in sarcoidosis is usually a uveitis and does not result in a cataract formation.

In retrospect, it appears that an antemortem diagnosis of Boeck's sarcoid in this patient would be extremely unlikely unless more serial studies of the chest disease had been available.

Summary and Conclusion

This patient is the fiftieth autopsied case of Boeck's sarcoid reported in the literature. This is the oldest recorded age (age 81). This patient illustrates a benign and chronic form of the disease, but the fact that this disease can be severe and of relatively short duration must be kept in mind.

The difficulty of antemortem diagnosis in some of the more benign types is illustrated by this patient.

BIBLIOGRAPHY

1. Rubin Eli. H. and Pinner, Max: Sarcoidosis, One Case Report and Review of Autopsied Cases, *Am. Rev. Tuberc.*, 49: 146, 1944.
2. Reisner, David: Boeck's Sarcoid and Systemic Sarcoidosis (Besnier-Boeck-Schaumann Disease) A Study of Thirty-five Cases, *Am. Rev. Tuberc.*, 49: 289, 1944.
3. Ronchese, F.: Sarcoid and Tuberculosis, Report of a Case With Autopsy, *Arch. Dermat. & Syph.*, 45: 860, 1942.
4. Thomas, C. C.: Sarcoidosis, *Arch. Dermat. & Syph.*, 47: 58, 1943.
5. Longcope, W. T. and Fisher, A. M.: Involvement of Heart in Sarcoidosis or Besnier-Boeck-Schaumann's Disease, *J. Mt. Sinai Hosp.*, 8: 784, 1942.

CHEST PHYSICIANS CANCEL MEETING

The American College of Chest Physicians, with a membership in 23 countries, has cancelled its annual meeting scheduled to be held at Philadelphia, June, 1945.

The Executive Council of the College voted to hold a business meeting of the Board of Regents at Chicago, June 17.

PHYSICAL THERAPY AT HOME FOR PERIPHERAL ARTERIAL DISEASE

CHRISTOPHER J. McLOUGHLIN, M.D.

Atlanta

As soon as a diagnosis of peripheral vascular disease has been made, a definite plan of therapy must be formulated. The immediate aim in the treatment of any peripheral vascular disorder is to reestablish and maintain an adequate supply of blood to the affected parts. The extent to which this can be accomplished depends upon the nature and the severity of the disorder and the efficiency and duration of the treatment. In the presence of organic disease of the arteries, permanent relief of symptoms depends on establishing a collateral arterial network. Considerable time is required to establish this collateral circulation so it is necessary to emphasize that the treatment of any peripheral vascular condition must be instituted early and continued for a long time if much is to be accomplished. The treatment of peripheral vascular disorders may be divided into two phases. The first consists of conservative therapeutic procedures which may be performed in the home. These measures should be instituted early and given every opportunity to produce the desired results. If no improvement is noted after a trial of many weeks of adequate therapy in the home it may be advisable to initiate the second phase of treatment. This generally will entail hospitalization and the employment of more complicated therapeutic apparatus such as would not be available to the patient in his home. Immediate hospitalization and treatment are imperative for patients with acute arterial occlusions, excruciating pain or ulcerative or gangrenous lesions. All other forms of peripheral vascular disease warrant a thorough trial of conservative therapy before subjecting the patient to the expense of hospitalization.

In outlining a conservative regimen for the patient to follow at home it is necessary that he be instructed in routine hygienic measures aiming at benefiting his physical

condition in general, and in particular attempting to improve circulation and relieve vascular spasm. The patient must be advised to wear warm clothing at all times for protection against cold and chilling of the extremities. It is advisable that he wear warm woolen socks coming almost to the knees, not only during waking hours but also when in bed. Properly fitted shoes of soft leather are essential. The feet should be given special care. It is far better to allow corns and callosities to remain untouched rather than to risk the possibility of initiating ulceration or gangrene. Slight trauma caused by the patient in trimming the nails or a callous may result in a series of changes which may lead to the need for amputation of the extremity. The feet should be bathed daily, using lukewarm water and a bland soap, then dried by patting or blotting with a soft towel, without rubbing, and with care being taken to prevent breaking the skin, especially between the toes. After this, the feet should be thoroughly dried with boric acid or some mild dusting powder. If the skin is very dry a gentle massage using cocoa butter, lanolin or olive oil will help to keep the skin smooth and soft. Hot foot baths have long been recommended as a means of producing arterial dilatation. However, alternate hot and cold foot baths are of much greater value and are just as simple to use. Two large buckets may be used for this purpose. One should contain water at a temperature of 105 degrees Fahrenheit (40.5 degrees C.), the other filled with cold tap water at 55 to 65 degrees Fahrenheit (12.7 to 18.3 degrees C.) Ice is not necessary for cooling the water and should not be used. The duration of immersion should be individualized for each patient. The average person with supposedly normal arteries will obtain the maximal effect of the bath by placing the feet in the warm water for a period of four minutes and then in the cold water for one minute. This alternation should be continued for twenty-nine minutes and should begin and end in the warm water. In the presence of vascular disease it is advisable to change the time of immersion to shorter periods in both the warm and the

cold water, and the bath may be given for twenty minutes twice or three times a day depending upon the severity of the condition. After the contrast bath the feet should be dried thoroughly by patting or blotting and sprinkled with boric acid powder or talcum. Contrast baths are not recommended if open wounds, gangrene, or ulceration are present. Trichophytosis or "athlete's foot" is to be suspected if blisters, or portions of cracked skin occur between the toes. This is particularly dangerous for patients with vascular disease as it may be the initiating factor in gangrene or ulceration. Many of the remedies suggested for trichophytosis are entirely too irritating to be used with safety. A reliable and advantageous treatment is to soak the feet for thirty minutes twice daily in freshly made solution of potassium permanganate (1:8000). Five grain (0.3 gram) tablets of potassium permanganate may be purchased at any drug store. One tablet added to two quarts of water will give the required concentration. This solution may stain the skin but is not injurious to the tissues.

If the condition of the patient will warrant, warm tub baths may be prescribed. In this procedure the patient should be immersed to the neck for twenty minutes in water, the temperature of which is from 100 to 104 degrees F. (38.3 to 40 degrees C.). This will produce a generalized increase in the circulation of the entire body. Caution must be exercised if there is any cardiac involvement, for it must be remembered that both hot and cold baths increase the work of the heart. Some physicians, knowing of the reactive peripheral dilatation which follows the application of cold, have advocated the use of cold showers and tub baths for vascular disease. However, this reaction of peripheral dilatation is prompt only in the healthy individual and applications of cold alone may cause ischemia and result in an increase in pain. Therefore, cold showers and cold tub baths are definitely contraindicated.

Heat may also be applied to the extremities by the use of a simple baker or heat cradle which can be made at home or purchased for a nominal sum. Many recom-

ment that the baker be used throughout the night but unless the lamp can be so protected so that the danger of burns is minimized, this procedure is not advisable. Heat cradles and bakers may be used at home for thirty minutes two or three times daily.

Massage is one of the oldest and most reliable means of stimulating circulation in a patient whose vascular system is normal. However, in the presence of vascular impairment massage may be dangerous, even when administered by the hands of a skilled technician. The hazards of producing injury in an already damaged vessel must always be considered. A thrombus may lead to gangrene and amputation. Therefore, massage if not considered as definitely contraindicated, should be used with extreme caution. Following any application of heat a routine of postural exercises is indicated. These should be prescribed individually for each patient and carried out twice daily for periods of fifteen to twenty minutes. In general, this routine should follow Buerger-Allen types of exercise. There are three steps in the routine: first, an inverted chair or small stool covered by a pillow should be placed on the bed. The patient should then elevate the limbs at an angle of 45 degrees until the more ischemic foot becomes blanched. Second, the legs may then be allowed to dangle over the side of the bed until rubor returns and the vessels have become dilated with blood. While the legs are in the dependent position, the ankles and toes should be exercised by rotating the ankles and alternately spreading and closing the toes. Third, in the final position the legs should be extended on the bed for two to five minutes. Thus the arteries will slowly fill and empty during this mild form of exercise. The presence of lymphangitis, or spreading infection, contraindicates the use of these exercises. The patient must be warned very carefully against the possibility of burns regardless of the method of heating prescribed. It should always be kept in mind that the cutaneous sensitivity of the patient to heat may be impaired and there may be anesthetic or hyperesthetic areas. Hot water bottles and electric pads are mentioned only to condemn them. An electric pad turned on at low heat will elevate the

temperature of an inanimate object to 100 to 140 degrees Fahrenheit; the medium heat may elevate the temperature as much as 180 degrees and the switch turned to maximum heat may cause the temperature to be elevated from 180 to 240 degrees F. It may be reasoned that a foot cannot be considered an inanimate object and that the circulation of the blood will redistribute the heat as it is brought to the tissues. However, a small area in which the circulation is impaired tends to collect heat in the same manner as an inanimate object so that the temperature may soon be elevated above the burning point of the tissue. Therefore, before any type of heating device is recommended to the patient, tests should be made to determine whether or not the cutaneous sensitivity is intact and normal.

A simple and effective therapeutic measure was described by Landis and Gibbon in 1933. They showed that by immersion of the hands and forearms of normal persons in water at a temperature of 110 degrees Fahrenheit (43.3 degrees C.) a vasodilatation of the lower extremities could be produced within thirty minutes and the temperature of the toes would increase from 18 to 27 degrees Fahrenheit (10 to 15 degrees C.). This is an excellent test for differentiating between simple spasm of the vessels with little or no organic obstruction, and organic vascular disease. In the former the cutaneous temperature of the toes usually will increase above 90 degrees Fahrenheit. When it will not go above 86 degrees Fahrenheit (30 degrees C.) organic arterial obstruction may be considered present. This test should be carried out at an early time in all cases to differentiate between organic disease and simple spasm of the arteries.

The use of paraffin as a means of applying heat has been strongly recommended. However, since the melting point of most paraffin is about 135 degrees it is inadvisable to apply it directly to extremities in which there is an impairment of circulation, for even when the wax shows signs of hardening it is still about 120 degrees F. Painting the arms and forearms of the patient with a coating of warm paraffin may be used if it is desired to produce a

reflex dilatation of the arteries of the lower extremities.

The therapies here recommended are all simple but efficient means of increasing circulation in extremities suffering from vascular disorders. Just as these vascular disorders will not begin abruptly but are slowly progressive, so too must progress toward improvement be made and the treatment be continued for weeks rather than days. The early use of such measures as these will produce so much improvement in the vast majority of patients that hospitalization and the use of more complicated apparatus will be unnecessary.

REFERENCE

1. Landis, E. M., and Gibbon, J. H., Jr.: A Simple Method of Producing Vasodilatation in the Lower Extremities, *Arch. Int. Med.* 52: 785-808 (Nov.) 1933.

RUPTURED UTERINE MYOMA SIMULATING RUPTURED TUBAL PREGNANCY WITH HEMORRHAGE

JAMES W. PILCHER, M.D.
DENNIS M. CORNETT, M.D.
GRADY N. COKER, M.D.
Canton

Mrs. F., aged 38, was first seen at midnight, in mild shock and complaining of generalized abdominal pain.

The afternoon of the same day, while working in her kitchen, she had a sudden, severe, stabbing pain in the lower abdomen which forced her to lie on the kitchen floor until help could be called. She stated that she would have fainted if she had remained on her feet. While lying on the floor the pain became generalized, her whole body hurting, but it was more pronounced in her abdomen, chest, and both shoulders. The severe pain lasted ten to fifteen minutes, by which time she was put to bed and her family physician called. The stabbing abdominal pain ceased, but the very exquisite tenderness and soreness in her abdomen, the chest pain, and the shoulder pain remained. Any movement and breathing caused great discomfort. Morphine, grain $\frac{1}{4}$, hypodermatically, and capsules for pain were given by the family doctor. The shot gave little relief. On several occasions during the afternoon, on sitting up, or using the bed pan, the patient had fainting attacks. By the next midnight there was no relief and she came to the hospital in an ambulance. While enroute to the hospital the patient became nauseated and vomited several times.

In the past the patient had had no severe illnesses and no operations. She had one child, aged 12; a normal gestation and delivery. Menses began at the age of 13, were of three to four days' duration, and a twenty-eight day cycle, and remained normal until about two years ago. At that time they became slightly irregular, at times going beyond the expected date and at other times too frequent. About this time she began having a dis-

charge which became more and more foul as time passed. About a year ago she had uterine bleeding which continued for about three months. Following this her periods were from two to three weeks apart, with many clots and frequent traces of blood in her discharge between the periods. From the date of admission her last period was four weeks ago, but she had been having a bloody discharge for three days before the onset of symptoms. She states that the last period four weeks ago was only of two days' duration and that she does not know whether or not it was a normal period.

Examination on admission revealed an obese white female in considerable pain. She appeared mentally clear but had an anxious attitude. Her pulse rate was 110, blood pressure was 105/70, and her heart and lungs were negative. The abdomen, on inspection, was obese, symmetrical, and possibly slightly distended. On palpation, generalized marked rigidity more pronounced in the right lower quadrant was present. Pressure and rebound tenderness were marked over entire abdomen, but more so in the right lower quadrant. On careful palpation a mass could possibly be felt in the right lower quadrant. Peristalsis was diminished on auscultation. A fluid wave was elicited in the abdomen, and considerable dullness in the flanks was present on percussion. Pelvic examination was difficult at this time due to the pain and rigidity. Great pain was elicited on movement of the cervix. A slightly enlarged uterus with several small subserous fibroids was felt. Also, a small indefinite mass in the right lower quadrant was likewise palpated.

Laboratory work showed: white blood count 12,800, with 88 per cent polys and a hemoglobin of 70 per cent. The urine showed a one plus albumin. Her temperature was 98.4.

Intravenous glucose and morphine in saline were administered and the patient's blood pressure was checked at frequent intervals. By the next day she showed great improvement in her general condition with much less pain, but still with considerable tenderness and rigidity of her abdomen.

The patient's condition remained improved and she did very well on conservative treatment until four days following the onset of her trouble, when again she had a severe attack of stabbing pain in the abdomen which again referred to her chest and shoulders. This severe attack lasted about five to ten minutes and left the patient with increased soreness and tenderness, which was relieved by morphine. The blood pressure at this time stayed within a safe range and the hemoglobin was only slightly decreased from that noted at admission.

The patient was posted for laparotomy the following morning, with a preoperative diagnosis of ruptured tubal pregnancy. A colpotomy was contemplated but was not done because laparotomy was definitely indicated.

Nitrous oxide induction, followed with closed system ether anesthetic, was used. A midline incision from the umbilicus to the symphysis pubis was made. On opening the peritoneum approximately 6 to 8 hundred cubic centimeters of fresh and old blood were present in the peritoneal cavity. The omentum was low in the pelvis. Multiple subserous fibroids were on the surface of the

uterus and one pedunculated fibroid extended on a pedicle into the right pelvic region, where it was partially fixed by adhesions. To one of the larger subserous fibroids the cecum, appendix, and omentum were loosely adherent. On removal these fibroids were found to have a large necrotic area which had eroded a large vessel from which a steady stream of blood was spurt- ing. It was evident that the cecum, appendix, and omentum had sealed the eroded vessel, thus partially controlling the hemorrhage temporarily.

Subtotal hysterectomy and appendectomy were done followed by an uneventful recovery.

WILLIAM SIMPSON ELKIN 1858 - 1944

The invitation to contribute lines to the memory of a life-long friend, an intimate professional and business associate, is a duty and responsibility not unmixed with overwhelming personal emotion. This friend is Dr. William Simpson Elkin, born April 26, 1858, in Lancaster, Ky., and who died in Atlanta, Ga., April 24, 1944, almost on the eve of his eighty-sixth birthday.

The son of a prosperous farmer of Garrard County, he was thoroughly prepared to enter Centre College, Danville, Ky., and, in 1879, received his A.B. degree. Three years later, 1882, his medical degree was conferred by the University of Pennsylvania. The rapidly growing City of Atlanta attracted him, and there he made his home until his death.

On October 26, 1887, he married Miss Nellie Duncan, of Lancaster, Ky. Their only child, a son, died in infancy. Mrs. Elkin died January 1, 1934. In October, 1935, he married Mrs. Nell Warren Osborne, of Stanford, Ky., who still survives him.

His nephew, Dr. Daniel Collier Elkin, is now Colonel and Chief of the Surgical Service in the Ashford General Hospital, White Sulphur Springs, W. Va.

Doctor Elkin early developed a marked ability as a surgical clinician in the out-patient department of the Southern Medical College. In a few years he was promoted to Professor of Clinical Surgery and Attending Surgeon of the Grady Memorial (Municipal) Hospital, of 400 beds. Following the consolidation of several medical colleges, he became Dean of the Atlanta College of Physicians and Surgeons, and from time to time, in conjunction with Dr. Abner W. Cal-

houn, Professor of Ophthalmology, contributed large sums in support of this institution.

The death of Dr. Hunter P. Cooper in 1906, and coowner of a private sanatorium, resulted in the formation of a partnership with the writer. He succeeded Doctor Cooper as Professor of Obstetrics and Gynecology. Sensing the spirit of the times, Doctor Elkin envisioned radical enlargement of hospital teaching facilities, and the absolute necessity of becoming an integral part of a virile University. Quietly and alone, he interested the Candler family, wealthy benefactors of the young Emory University (the parent Emory College at Oxford, Ga., 40 miles distant) and, in 1915, the renamed Atlanta Medical College became the Medical School of Emory University. The writer is confident that no other man could have so aroused the enthusiasm and interest in such a huge and mutually advantageous enterprise, in securing donations and an endowment of millions of dollars. Upon his retirement in 1925, the degree of LL.D. was conferred by Emory University, and, in 1929, a like degree honored him by Centre College.

Doctor Elkin was a deacon of the First Presbyterian Church, Director of the First National Bank, a Mason, a Democrat, and a member of several exclusive social clubs. He was a member of the Southern Surgical Association since 1890, a Founder, in 1913, of the American College of Surgeons, twice past President of the Fulton County Medical Society, and, of course, affiliated with the district, State and National organizations. He enjoyed a handsome income from a large city practice and a State-wide consultation clientele; and by thrift, and unusual business sagacity, amassed a comfortable fortune.

Doctor Elkin's standard of citizenship was high. All worthy religious, civic and charitable projects found his purse open, and he often remarked that it was the obligation of every good citizen to register and vote for the lowest to the highest office. He invariably evinced anger when anyone, legally eligible and physically fit, endeavored to avoid jury duty. There was no personal political ambition in him, although he was

often invited to participate in conferences in various legislative bodies because of his unusual sound sense and forthright principles. Golf finally lured him from the exactions of his professional work. His great personal charm and *camaraderie* in the enjoyment of congenial companionship on the links gave his fellow players unforgettable pleasure.

Other than an occasional trip to Europe and winter cruises in the Caribbean, or a few weeks at Palm Beach, the outstanding event in the last half of his life was the Kentucky Derby week, where for many years he maintained a large box and dispensed gracious hospitality to a wide circle of friends.

The death of Dr. William Simpson Elkin marks the passing of an irreplaceable friend, a wise counselor, and, in the opinion of the writer, the greatest all-around Doctor he has ever known.

WILLIAM S. GOLDSMITH, M.D.

(This article was written at the request of the officers of the Southern Surgical Association, and appeared in the May 1945 issue of the ANNALS OF SURGERY, official publication of that Association; and will be incorporated in the transactions of the Association for 1944. It is republished in THE JOURNAL with the permission of the author and the publishers of ANNALS OF SURGERY, the J. B. Lippincott Co., Philadelphia.—Ed.)

CONVENTIONS VIA THE MAILS

The record is now 100 per cent. What I mean is that, as of today, there is practically nothing remotely connected with human endeavor that is not offered and cannot be procured by simply filling out that blank space and mailing to the proper authority. It has long been only stubbornness that prevented every woman from facing the world with devastating charm and beauty, every facility for achieving both could be placed in her mail box. A day to day horoscope and life's doubts vanish, and nobody need suffer the humiliation of staying home night after night. There are neat little courses guaranteed to put your name at the top of every guest list, in the meantime imparting a vocabulary tending to increase your brilliance while turning words into your slaves. When more and better executives are made the mail man will have a hand in it. Just stay at home and he will beat a path to your door with everything from brain to brawn. A boon to mankind all, but they pale into insignificance beside the latest contribution to progress: the complete technique of conducting conventions by mail.

With my accustomed efficiency I have mislaid the article dealing with this answer to the cry for help from a war-torn, conventionless world, thus I can boast of no reliable knowledge as to the rules and regulations connected with this gift from some unknown benefactor. Some stringent clause may blight forever long-cherished desires to doze through introductions to introductions, and to sit barefoot through those few words that inevitably consume two hours. It is entirely possible that these packeted conventions are accompanied by a stern-visaged monitor who will tolerate no infringements upon accepted convention behavior. Should this be true the thing has gone from bad to worse and will not long survive. Barring such a calamity, however, the new order will bring peace and contentment to countless souls.

The inhibitions and complexes accruing from mass gatherings will not longer torment us. The craving to become an executive is not shared by all, but the yearning to talk back to them is universal. The longing to contradict, and loudly, everything uttered by our betters need not be stifled. You can answer as you please and no holds barred. Your extemporaneous address will be forceful and overpowering, two ingredients which formerly eluded you until you sat down. For it can be made at frequent intervals. Whose floor is it, anyway? Neither must you submit to majority opinion. There will be no glares if among the entire convention yours is the only nay.

But upon the ladies will fall the greatest blessings. In spite of all we can do there is always some creature whose wardrobe justifies homicide. Our dashing hats either met their twin or their superior, either of which is fatal, and no matter what we wear we writhe because it isn't something else. Now we can hold our own. Ah, the wonderful convention by mail; now we will be able to observe first-hand those hardships from which the gentlemen emerge limp and shaken. Or will we?—MARGARET COWDEN JONES, Fort Valley, *The Atlanta Constitution*, March 5, 1945.

CIVILIAN COMMITTEE TO AID ARMY'S PROGRAM FOR THE BLIND

An Honorary Civilian Advisory Committee to The Surgeon General has been formed to cooperate in the Army's social adjustment training program for the blind. All members of the committee are individually prominent in civilian work for the blind.

At the first meeting held March 21, at the American Foundation for the Blind in New York City, Dr. Robert B. Irwin of New York City was elected chairman, and Mr. Joseph C. Cauffman, of Overbrook, Pa., secretary. Mr. Peter J. Salmon, of Brooklyn, N. Y., Mr. W. L. McDaniel, of Washington, D. C., and Mr. Henry P. Johnson of Tampa, Fla., were elected field consultants. These constitute the Executive Committee.

THE PRESIDENT'S PAGE

CURRENT MEDICAL LEGISLATION

Recently there have been introduced in legislative halls bills that affect the interests of the medical profession.

The Hill-Burton hospital construction bill proposes to provide adequate hospital facilities of a high quality for all the people of this country, where such are deficient, and carries an appropriation of \$110,000,000. The Board of Trustees of the American Medical Association has given consideration to all details of the bill and find its general policies are within the platform of the A. M. A., according to Dr. R. L. Sesenich, member of that board. It carries a minimum of regimentation with a maximum adaptability to local conditions.

The recent session of the Georgia Legislature passed a resolution (113-606b) that reads in part:

The State Board of Health is designated and authorized to become the channeling agent on behalf of the State for such health funds as may be made available by the Federal Government.

The State Board of Health shall expend all funds received from the Federal Government, or by appropriation from the State of Georgia, or by donation in conformity with the law. In the expenditure of such funds the State Board of Health shall have the authority to prescribe the purposes for which such funds may be used.

The State Board of Health shall provide for a State Advisory Council on health work which shall include representatives of non-governmental organizations or groups, and all State and local agencies concerned with the operation, construction, or utilization of hospitals

and hospital facilities. The said Advisory Council shall diligently undertake to obtain all possible available Federal funds for health work in Georgia, and shall make recommendations to the General Assembly through the State Board of Health as to how Georgia may best serve the interests of the people through expanded health services.

The Murray-Wagner-Dingell bill is to be re-introduced in Congress at any time now, re-written but of the same import as the former bill.

There is the bill (S. 637) concerning deferment of premedical and predental students before the Senate Committee on Military Affairs. A favorable treatment of this bill is urgent. The Navy and Army students entering medical schools are being reduced in number so rapidly that by 1946 there will be only 10 per cent of them composing freshman classes; thus 90 per cent must be obtained from civilian sources. If civilian premeds are inducted into the services now it will be impossible to fill the quota of students from men under 17, men physically disqualified; women, and veterans. There is in 1945 a vast inadequacy in qualified civilians entering medical schools.

"He who runs may read," and no matter how hard we are having to run these days we should keep our attitudes moving in line with the needs of our day. Benjamin Franklin said: "He who spits against the wind, spits in his own face."

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

MAY, 1945

WHAT WILL MR. TRUMAN DO ABOUT MEDICINE?

With the change in the national administration, the question arises: What will President Truman do about medicine?

Latest information indicates that fully 67 per cent of the members of the present Congress are opposed to the socialization of medicine. Many of them believe that changes in today's system must come, and no doubt most of them are willing to help in any program which will benefit the most people.

Pending information regarding President Truman's attitude towards medicine, it is well that all of us re-examine the Platform of the American Medical Association, revised in 1944.

1. *Availability of medical care of a high quality to every person in the United States.*

In carrying out this widespread distribution of medical care and in any evolution necessary in the methods of administering medical care, the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered must be maintained.

It is not in the public interest that the removal of economic barriers to medical service should be utilized as a subterfuge to overturn the whole order of medical practice or the democratic plan of government. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and postgraduate medical education be energetically developed. Curative medicine, public health medicine, research medicine and medical education all are indispensable factors in promoting the health, comfort and happiness of the nation.

In carrying out this objective, the American Medical Association advocates:

A. *In the extension of medical services to all people, the utmost utilization of qualified medical and hospital facilities already established.*

There is no evidence that the American people wish different doctors or a different system of medical care. There is evidence that they wish

that care more widely distributed and they wish some method of easing its economic burden, especially by pre-payment plans. That the people desire a personalization of service is evidenced by the fact that in the present time of full employment the turnover in charity hospitals is at a new low and the semiprivate and private beds in the private and voluntary hospitals are overcrowded, whereas in times of slack employment the reverse is true.

The extension of hospital facilities should be carried out only after a careful survey which indicates that present hospital facilities are being used to the utmost or that there is a definite lack of hospital beds for a particular community.

Again, it has been argued that the demands for medical care in some sections of the country might require the importation of considerable numbers of physicians or the transportation of numbers of physicians in the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities. There are many emergency situations which may arise in time of war. In most instances these emergencies will not continue after the war. Where they do, other arrangements must be made to meet them.

B. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.*

In the United States today our sickness and death rates are lower than those of any other great country in the world. This fact is generally recognized. The medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner subject to the control of public officials would in any way lower sickness and death rates. Compulsory sickness insurance in no instance has given as good a health record as the American system.

The medical profession has approved prepayment plans to cover costs of hospitalization and also prepayment plans on a cash indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has

taken place in this country has led to higher standards of medical practice and of medical service than are elsewhere and that the maintenance of the quality of the service is fundamental in any health program.

The American Medical Association has approved prepayment hospital insurance subject to the principles adopted by the House of Delegates. The number of people covered by it is constantly increasing. Its availability should be extended to all who desire it.

Medical expense insurance has developed slowly, but much valuable experience has been accumulated. All constituent state associations have been urged to develop voluntary plans within their territory so that the entire country may be covered by such plans. The American Medical Association will assist in the development, correlation and integration of such plans. State welfare departments should consider the use of the insurance principle in caring for the indigent and medically indigent, rather than the present system. Industrial medical care plans on the voluntary principle must be investigated and developed under the guidance of constituent associations and component societies.

C. Expansion of public health and medical services consistent with the American system of democracy.

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price to pay for security.

D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amounts to at least \$1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels

however that, in many instances, states have sought aid and appropriations for such functions without any actual need on the part of the state, in order to secure federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be provided for health purposes; that these funds be administered jointly by the county, state and federal health agencies, mentioned in section H of this platform, and that the funds be allotted on proof of actual need to the federal health agency, when that need is for the prevention of disease, for the promotion of health or for the care of the sick.

E. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

Obviously if federal funds are made available to the individual states for the purpose mentioned in section D of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose and, in effect, to demand that the federal government take over the problem of the care of the sick. Hence it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their need to the federal health agency, and that the health agency determine whether or not the community has done its utmost to meet such need before allotting federal funds for the purpose.

F. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

The medical profession wishes to extend preventive medical services to all people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation, such mechanism may be suitably outlined.

So far as preventive medicine and general measures of public health are concerned, there is great need for the increase of county or district departments of health. There are still too many areas without such coverage. Every area in the United States should have a health service with adequate personnel and facilities to render the service necessary to each community. It should be integrated with and coordinated by the state health department. Federal funds may be

used to help establish these departments where local funds are inadequate, but the management should be under state and local authority.

G. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

The medical profession does not yield to any other group in this country in its desire to extend medical care to all those unable to provide themselves with medical service. The American Medical Association has already recognized the existence of a group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities but not capable of meeting a medical emergency. Hence, it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by federal government, as they are the most capable of determining the needs. Emergency and migratory labor may be a temporary federal responsibility. The use of the voluntary insurance principle should be considered by all agencies distributing medical care.

H. The establishment of an agency of federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus and federal agencies. Thus, the United States Public Health Service and the Food and Drug Administration are in the Federal Security Agency; the Children's Bureau in the Department of Labor; the Veterans' Administration and many other medical functions are separate bureaus of the government.

Since 1875 the American Medical Association has urged the establishment of a single agency in the federal government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

EDUCATIONAL OPPORTUNITIES FOR ARMY DOCTORS

Since the start of World War II, over 6,000 selected medical officers have been graduated from short but intensive courses given by the Medical Department in some thirty critical

medical and surgical specialties, according to Major General George F. Lull, Deputy Surgeon General. In addition, refresher courses in general medicine and surgery provide medical officers with a chance to "brush up" before returning to professional assignments after other duty.

Many doctors also benefit while in service from working under key professional personnel in military hospitals. Other medical officers who have been on duty with combat troops in the field are given an opportunity to brush up on their specialty through the rotation policy.

General Lull reported that 350 doctors have been reassigned from field to hospital duty during the past year in the Mediterranean Theater and "the merit of intra-theater rotational plans has been pointed out to other theaters, and is being encouraged in order that the maximum number of doctors might receive refresher training while they are still in military service."

Naturally, professional training of medical corps officers during military service must be restricted to meet military rather than civilian requirements. However, General Lull said, the Surgeon General is keenly interested in the welfare of these doctors and will provide "insofar as is possible" opportunities for professional training.

In the post-war period, he added, all doctors will be entitled to professional training, after their release from service, under the G. I. Bill of Rights, and those who remain in the Army will have the opportunity for refresher training at selected military hospitals and civilian schools.

FAVORABLE REPORTS ON TRENCH FOOT

Reports from the Army general hospitals at Camp Butner, N. C., and Camp Carson, Colo., which are trench foot treatment centers, indicate that the cases now under treatment are for the most part mild. Lieutenant Colonel Roy H. Turner, M.C., Acting Director, Medical Consultants Division, Office of The Surgeon General, who recently returned from an inspection trip, stated that, with the exception of a very small percentage of cases, evidence of injury to the feet is slight and recovery is both rapid and exceedingly satisfactory.

The mildness of trench foot cases now being hospitalized is largely due, in the opinion of Colonel Turner, to the Army's intensified education of troops concerning trench foot which has resulted in the prompt reporting of cases, early diagnosis, and immediate treatment.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

The Barrow County Medical Auxiliary met April 6 at the home of Mrs. S. T. Ross, with Mrs. C. B. Almand, president, in the chair.

Mrs. S. T. Ross, Doctors' Day chairman, announced the observance of Doctors' Day Sunday, April 1, by the churches. The Auxiliary sent letters to the members of the medical corps and biographies and pictures of Dr. Crawford W. Long were given to the county schools. An appropriate program honoring the memory of Dr. Long was conducted by Miss Mary Jane Williams at the chapel exercises in the Winder High School. Dr. Long's grave and those of Barrow County physicians were decorated.

During the business session the following officers were elected to serve for the ensuing year: Mrs. R. H. Randolph, first vice-president; Mrs. C. B. Almand, second vice-president; Mrs. E. R. Harris, recording secretary; Mrs. W. L. Matthews, corresponding secretary; Mrs. W. T. Randolph, treasurer; Mrs. E. M. McDonald, historian and Mrs. C. B. Almand, parliamentarian. At the conclusion of the business meeting, Mrs. W. T. Randolph, state president, addressed the meeting using as her topic "The Work of the Medical Auxiliary."

Light refreshments were served by the hostess during the social hour.

* * *

The Auxiliary to the Georgia Medical Society met at the home of Mrs. R. L. Neville in Savannah at 11 o'clock Friday, April 6, 1945. The meeting was called to order by the president, after which the Lord's Prayer was said in unison. A letter was read from Dr. S. Elliott Wilson thanking the ladies for the refreshments served the Medical Society on Doctors' Day.

This being the annual meeting, the chairmen of all committees gave their reports after which the president, Mrs. S. Elliott Wilson, gave her report, which was received with a rising vote of thanks. Mrs. R. L. Neville took the chair during the president's report. The Auxiliary's first yearbook, prepared by Mrs. Charles Usher, was presented for inspection. Mrs. Sam Rosen read the original poem written by Mrs. A. A. Morrison, Jr., in honor of the doctors and presented at their Doctors' Day celebration. Mrs. H. M. Kandel made a motion, which was seconded by Mrs. Charles Usher, that this poem be incorporated in the minutes:

"Dear Doctors:

"On this memorable day — we wives wend our way
Right up to your brass shingled door
We haven't a pain or a headache
But only bring wishes galore —

"May this day be one that is empty of war
And of surcease from worry and strife
May your night be a glory of peace and content
That comes from a useful life.

"And when at the end of all Doctors' Days
And from all of your calls you may rest
May sweet memory's treasures brighten your way
To a fairer home — eternally blest."

Mrs. Charles Usher suggested that this poem be incorporated in the Yearbook for 1945-46 which met with the approval of the Auxiliary.

Mrs. R. V. Martin moved that the Auxiliary give \$5.00 to the Jane Todd Crawford Memorial, which motion was seconded and passed to the treasurer for payment.

Report was received from Mrs. H. M. Kandel on the Health Education program convention. Mrs. J. L. Elliott moved that the Auxiliary contribute half a scholarship, \$37.50, for a health education course offered at the University of Georgia during the summer months for one of our local teachers. This was seconded and passed.

Following officers for next year were elected:

Mrs. R. L. Neville, President.

Mrs. H. M. Kandel, 1st Vice-President.

Mrs. E. Ham, 2nd Vice-President.

Mrs. Charles Usher, President-Elect.

Mrs. L. W. Williams, Treasurer.

Mrs. R. E. Graham, Corresponding Secretary.

Mrs. Hugo Johnson, Jr., Recording Secretary.

Mrs. R. V. Martin asked that Mrs. John L. Elliott, chairman of War Participation, distribute questionnaires to be filled in and returned to the War Service Committee showing the war service performed by each member.

The next meeting is to be held in June at the home of Mrs. Lee Howard.

* * *

The American Medical Association, through the Bureau of Health Education, offers the Auxiliary several ways of cooperating in health education by radio, one of which is the 30-minute dramatized program entitled "Doctors Look Ahead" each Saturday afternoon at 3 o'clock

(Continued on page 103)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALNUT 8911; residence, JACKSON 7979.

NURSING IN WARTIME

MRS. LESSIE K. CATHER, *Chairman*
State Nursing Council for War Service
Atlanta

Defending the Cause—The Real Facts in the Case of Draft For Nurses

"You can draft nurses but you can't draft the spirit of nursing" is a statement made by Miss Mary Roberts, editor of *The American Journal of Nursing*, when she asked for real facts concerning the draft for nurses bill now pending in Congress.

Nursing leaders in Georgia and throughout this country are anxious that both sides of the question be presented to the people and that the public understand the nurses' position. From the date of the President's call for a National Service Act, a Limited Service for All Women, and a Draft for Nurses, the American nurses set to work to outline effective legislation. The statement the president of the American Nurses' Association made to the House Military Affairs Committee will be quoted boastfully by not only nurses, but by all those interested in maintaining a *democratic way of life*, and the *Health of A Nation*.

The Georgia State Nurses' Association is in full accord with the American Nurses' Association but as yet H. R. Bill 2277, now pending in Congress, does not include all of the basic principles suggested. Mainly omitted was the limited selective service for all women.

Your attention is called to the facts leading up to the Army's demand for a Draft for Nurses. Army regulations prevented men nurses from being assigned to the Army Nurse Corps. Some 9,000 men registered nurses are in this country. Discrimination was tolerated as to color and sex.

Bottlenecks were permitted in *clearing applications* to both Navy and Army Nurse Corps. Hours and days of registered nurses' time were devoted to classifying and recruiting nurses through the limited facilities of the American Red Cross and on voluntary service which should

have been financed and staffed with a direct program from the Army and the Navy.

Nurses all over the country were confused over the quotas received which were up one month and down another. No wonder the critical need was not realized.

Now nurses have applied for assignment in such large numbers that many are waiting to be cleared. There are many Georgia nurses who have resigned their civilian positions and are waiting for military placement. Georgia's Navy Nurse Corps quota has been met and Georgia is nearing her Army Nurse Corps quota for this year.

We urge immediate elimination of all bottlenecks and that a direct recruitment program be established, financed and staffed by the Army and Navy.

Georgia nurses are proud of their military record and will continue to recruit but are distressed over the inadequate civilian nursing service which leaves many of the hospitals with perhaps one registered nurse, and many counties without a registered nurse.

The position of the National Nursing Organization on War Nursing needs are summed up briefly in a statement as follows:

1. "The care of wounded service men is the first responsibility of the nursing profession.
2. "Nurses' voluntary response has been outstanding, but not rapid enough to keep pace with mounting casualties or with the newly-raised Army Nurse Corps ceiling of 60,000.
3. "Selective Service for all nurses is acceptable only as the first step in selective service for all women, but this should be supplemented by a national service act applying to all men and women.
4. "With one-fourth of all active nurses in the armed forces, civilian nursing should operate on a carefully planned minimum, in which every nurse does essential nursing.
5. "Civilian health requires more assistance

by men and women, paid or volunteer, at every level where they are competent to serve in health agencies and institutions.

6. "Efforts should be made to increase the number of students in the U. S. Cadet Nurse Corps as a present major source of nursing care for civilians and a reservoir of future care for armed forces.
7. "Military nursing needs should be met on a selective basis—whether voluntary or under draft—so that nurses most difficult to replace in key civilian positions are among the last to be taken.
8. "Voluntary recruitment should be intensified and nurses who are eligible and available should enlist now, regardless of legislation, because *the need is now.*"

ANNOUNCEMENTS

Cancellation of the Annual Joint Conference of Georgia State Nursing Groups. Due to the ruling made by the Defense Transportation Director to the effect that only meetings and conventions can be held during 1945, where there are fifty persons or fewer travelling to attend, our Annual State Meeting usually held in the fall has been cancelled. There will be held in August, in Atlanta, an executive board meeting of Georgia State Nurses' Association and perhaps other smaller groups of executive boards to discuss important nursing matters and to make plans for a program for the coming year.

The Georgia State Nurses' Association is grateful for the safe return of three of her nurses after nearly three years of imprisonment by Japs at Santo Tomas Camp. They are as follows:

Lt. Frances Nash, A.N.C.,
Graduate of Grady Hospital, Atlanta,
from Washington, Ga.
Lt. Mildred Dalton, A.N.C.,
Graduate of Grady Hospital, Atlanta,
from Jefferson, Ga.
Lt. Kathryn Dollason, A.N.C.,
Graduate of University Hospital, Augusta,
from South Carolina.

NOT CANCELED

The art contest sponsored by Mead Johnson & Company on the subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians) has *not* been canceled or postponed.

The closing date remains May 27, 1946.

There will be no annual exhibit *this year* of the American Physicians Art Association, due to the cancellation of the American Medical Association meeting which had been scheduled to take place in Philadelphia, June 17-22, 1945.

For full details regarding the \$34,000 prizes and the "Courage and Devotion" contest, write Dr. Francis H. Redewill, Secy., A. P. A. Assn., Flood Bldg., San Francisco, Cal., or Mead Johnson & Co., Evansville, Ind.

AUXILIARY NEWS

(Continued from page 101)

CWT. Descriptive circulars for distribution in your community are available. The National Broadcasting Company reports 123 stations taking this program and broadcasting it locally, which is the largest network such a program has ever had. The local Auxiliary can build up a listening audience by advertising the program locally, organizing listening groups and writing letters of appreciation to local radio stations which broadcast this program. The radio station derives no profit and is therefore making a contribution to the public welfare.

Georgia Auxiliary members appearing on list of standing committees of the Auxiliary to American Medical Association are:

Legislation Committee—Mrs. Olin S. Cofer, Atlanta.

Chairman of Organization—Mrs. Eustace Allen, Atlanta.

War Service Committee—Mrs. James N. Brawner, Atlanta.

NEWS ITEMS

Dr. Murdock Equen, Atlanta, was signally honored Friday evening, April 20, by being awarded The Gold Medal for 1944 from The Thomas A. Edison Foundation. The presentation was made before an audience in The Academy of Medicine of 300 colleagues, friends and patients. Dr. Equen's family was present, including Mrs. Equen, their daughters, Misses Anne and Carol Equen, Dr. and Mrs. Dunbar Ogden, New Orleans, La., Mr. Stanard Equen, Mr. Earle Equen, Greenwood, Miss., Mrs. Augusta Equen, Columbus, Miss.

Dr. Joseph C. Masee, president of Fulton County Medical Society, presided. He first paid tribute to the members of the Society who have brought credit to themselves and to the Society by their attainments, including our members in service, and saying how happy he was that another member had so distinguished himself.

Dr. Edgar G. Ballenger, president of the Southern Medical Association, gave a short biographic record of Dr. Equen and his work which was interesting and showed his early interest in bronchoscopic work.

Dr. Robert D. Hobday (Ph. D.), president of the Thomas A. Edison Foundation, gave something of the history of the Foundation, relating Mr. Edison's numerous contributions to science and stated he had observed in Dr. Equen something like Mr. Edison—his indomitable will to succeed, his ability and capacity for work, his kindness and sympathy toward mankind. He stated he feared an emergency of a foreign body might keep Dr. Equen from attending. Dr. Hobday paid tribute to Governor Ellis A. Arnall, saying he had become a national figure bringing honor to Georgia.

Governor Arnall made the presentation of the medal, commending Dr. Equen for his work, his devotion to duty, his charitable work and his ingenuity in designing such a life-saving instrument as the alnico magnet. He explained alnico, so named because of the three

metals used in it—aluminum, nickel and cobalt. He gave the names of outstanding members on the Board of Directors of The Foundation, including such men as Herbert Hoover, Fred W. Rankin, Ray Lyman Wilbur, Chevalier Jackson, et al. He also stated that outstanding physicians over the country are asking to use the instrument.

Amid the applause and numerous floral gifts from friends, Dr. Equen accepted the Gold Medal with modesty, giving credit to Mr. Robert Crockett of the Atlanta office of General Electric, Prof. J. H. Howey of the physics department of Georgia Tech and his co-workers who worked with him in perfecting the instrument which has proved to be so useful in removing foreign bodies from the lungs and stomach.

Dr. John M. Walton, Atlanta, who has been connected with Atlanta and Georgia public health departments for the past eight years, has been named associate medical director of the southeastern area of the American Red Cross.

Doctors' Day. Eleven years ago the Woman's Auxiliary of the Medical Association of Georgia adopted a resolution designating as "Doctors' Day" March 30, the anniversary of Crawford W. Long's epoch-making use of ether anesthesia. It was a beautiful idea which has grown into an annual custom and which has spread into other states. We all may well join with the Woman's Auxiliary in paying heart-deep tribute to a profession whose members, both on the world-wide battle fronts and on the home front, are rendering truly heroic service. *The Atlanta Journal*, March 30, 1945.

The Tri-County Medical Society, Blakely, held its regular meeting March 29, 1945. The following officers were elected for 1945: President, Dr. S. P. Holland, Blakely; Vice-President, Dr. C. K. Sharp, Arlington; Secretary-Treasurer, Dr. J. G. Standifer, Blakely; Delegate, Dr. J. G. Standifer, Blakely; Alternate Delegate, Dr. C. W. Hays, Colquitt; Board of Censors: Dr. W. H. Wall, Blakely; Dr. E. B. Baughn, Colquitt; Dr. E. R. Bridges, Leary.

The Medical and Surgical Staff of the Georgia Baptist Hospital, Atlanta, dinner meeting was held April 17 in the Nurses' Home dining room. Dr. Chas. E. Rushin was in charge of the Clinico-Pathologic Conference.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton St., Savannah, April 10, 1945. Scientific paper: "Electrocardiography—Its Clinical Significance in Diagnosis and Treatment," Dr. C. Y. Bailey, U. S. Marine Hospital, Savannah. Members of the armed forces were especially invited.

Dr. J. C. Loranger, New Holland, physician and surgeon, a graduate of the University of Georgia School of Medicine, Augusta, has moved into his office over Evans Dry Goods Store, Claxton.

The Bibb County Medical Society held its regular meeting at Ridley Hall, Macon, April 17, 1945. Scientific program: "Cancer of the Larynx," Dr. W. L. Barton.

The Muscogee County Medical Society, Columbus, and the professional staff of the Regional Hospital, Fort Benning, were guests of Colonel V. E. Powell at a meeting at the Post Hospital, March 27. Colonel Powell illustrated the reconstruction of injured military personnel by color-slide presentations of orthopedic conditions, revealing the actual wounds, followed by method of treatment, and the final results. Colonel Powell invited members of the Medical Society to attend future meetings of the military physicians, and Dr. O. D. Gilliam, vice-president of the Muscogee County Medical Society, urged military doctors to attend all meetings of the society.

The Richmond County physicians wore dark red carnations presented them by members of the Medical Auxiliary in commemoration of Doctors' Day which was originated in 1933 by the Woman's Auxiliary to the Barrow County Medical Society. The idea and plan were presented in 1934 at the annual state meeting in Augusta and the following resolution adopted: "Resolved that March 30, the day that the famous Georgian, Crawford W. Long, first used ether anesthesia in surgery, be adopted as Doctors' Day, the object to be the well-being and honor of the profession. Its observance demanding some act of kindness, gift or tribute."

Crawford W. Long Day was observed at the University of Georgia, Athens, March 30, with special exercises. This was the 103rd anniversary of the use of ether anesthesia in surgery. Dr. Russell H. Oppenheimer, dean of Emory University School of Medicine, Atlanta, spoke on "Preparation for the Practice of Medicine." Entering the University of Georgia at 14, Dr. Crawford W. Long graduated with a master of arts degree in 1855.

Dr. J. A. Thrash, Columbus, was recently re-elected Muscogee County public health commissioner, a position he has held since 1939. He plans for a more intensive program through establishment of a health education department. He has won high praise of the County Board of Health for his efforts for the tuberculosis control program and the acquisition of small x-ray equipment to aid in early discovery of signs and symptoms of tuberculosis.

The Bibb County Medical Society, Macon, dinner meeting was held at the New Yorker Cafe, April 3, 1945. The scientific program: "Penicillin in the Treatment of Syphilis," Captain J. Z. McDaniel, Robins Field, and Dr. Edwin R. Watson, Atlanta.

The Georgia Medical Society held its regular meeting at 612 Drayton Street, Savannah, April 24, 1945. Paper: "Congenital Choanal Atresia (Congenital Closure of Posterior Nares). Review of Literature and Report of Two Cases," Dr. George H. Faggart.

OBITUARY

Dr. William A. Mulherin, aged 72, of Augusta, died at his residence April 19, 1945. His life was long and sweet; his last illness short. His work for organized medicine in Georgia and in the nation was an example of unselfish service, he having served in various positions in his county, state and national organizations. He was a past president of the Medical Association of Georgia and was, at the time of his death, one of the three delegates from the Association to the American Medical Association. His services to his community are best portrayed in an editorial in the *Augusta Chronicle* of April 20, 1945, which follows:

"Dr. Will Mulherin died after having given a lifetime of unselfish service to the people of his community, not only in a professional way as a practicing physician, but as a friend and counselor as well.

"As a specialist in the diseases and care of children, he was without a peer. But he was more than a doctor. He was a friend and comforter and confidant of the little people whom he attended in sickness.

"Untold hundreds of Augustans today owe their robust health and wholesome outlook on life to the ministrations and tender care given them in their childhood days by Dr. Will Mulherin.

"He understood child psychology. He had the peculiar genius of being able to completely win the confidence of his tiny patients; he could soothe them and banish their unreasonable fears while he hound their wounds and healed them. His gentleness and tenderness were as much a part of his medical equipment as the instruments he carried in his doctor's handbag.

"In the kindly eyes of Dr. Will, all of his patients were 'Little Sister' and 'Little Brother.' He was a friend of them all. He loved them all.

"Dr. Mulherin, aside from his practice, made a real contribution to the advancement of medicine and the improvement of public health facilities in this community. He worked for years in the interest of the Board of Health, the University Hospital, and the Medical College, and contributed his time and energies and knowledge without stint in behalf of medical science and the improvement of the health of the community.

"The rigorous duties of an elderly physician who felt called upon to carry on at home in the absence of the younger doctors who had gone to war added an extra strain on his strength.

"When the war broke out, Dr. Mulherin was preparing to lead a less active life, having reached the age when he was entitled to retirement; but when his two sons, Colonel Philip Mulherin and Captain Charles Mulherin, both doctors, were called to the colors, he felt that it was incumbent upon him to carry on. And so he was shouldering burdens and work far too heavy for a man of his age when death ended his life and career.

"Dr. Will Mulherin was loved by all Augustans. He will be sorely missed by us all."

Dr. H. D. Carson, aged 73, Union Point, died in the Athens General Hospital March 28, 1945. He was the

son of the late Alfred and Mary Carson of Franklin County. Dr. Carson was graduated from the University of the South Medical Department, Sewanee, Tenn., in 1899 and located in Union Point where he continued the practice of his profession throughout the years. He was a member of the Greene County Medical Society and the Medical Association of Georgia. He is survived by his wife, the former Miss Susie Dolvin; two sons, Lt. Marcus Carson of the European Theatre of War, and Clayton Carson, U. S. Navy, Miami, Fla.; a daughter, Miss Mary Carson, Atlanta; also by two brothers and three sisters. Funeral and burial in Union Point.

Dr. Carroll William Downey, aged 69, Tallapoosa, died in an Atlanta hospital April 8, 1945. He was graduated from Emory University School of Medicine, Atlanta, in 1898. He was a member of the Haralson County Medical Society and the Medical Association of Georgia. Dr. Downey is survived by three daughters: Mrs. L. Downey Slahive, Americus; Mrs. C. C. Johnson, Richmond, Va.; and Mrs. H. L. Matthews, Chattanooga, Tenn.; and five sons: Atwood and Garland Downey, Tallapoosa; Marion, Roderick and Dr. William P. Downey, all of the United States Navy. The body was taken to Landrum, S. C., for funeral and burial.

Dr. William D. Sears, aged 68, Ellaville, prominent retired physician, died at his home March 14, 1945. He was the son of the late Dr. W. J. Sears and Mrs. Lou Lockhart Sears of Talbot County. In 1882 he was graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta. Dr. Sears was a member of the Sumter County Medical Society, the Medical Association of Georgia, and the Ellaville Baptist Church. He is survived by his wife, Mrs. Emma Battle Sears; three daughters, Mrs. Bessie Lou Lightner, Ellaville, Mrs. Harold Head, St. Petersburg, Fla., and Mrs. B. T. Rainey, Buena Vista. Funeral services were held at the Ellaville Baptist Church with Dr. E. W. Dupree officiating, assisted by Rev. Roy J. Bond, pastor of the Ellaville Methodist Church, and Rev. J. R. Smith, Buena Vista. Interment was in Ellaville cemetery.

Dr. Benjamin G. Swanson, Jr., aged 62, Atlanta, died in a Savannah hospital March 17, 1945. Dr. Swanson was born and reared in LaGrange, but had made his home in Atlanta until a few months ago when he went to Savannah to assume the duties of the practice of a physician called into military service. He graduated from the University of the South Medical Department, Sewanee, Tenn., in 1907. Surviving are: his wife, the former Miss Ellie Ridley, LaGrange, now of Atlanta; a daughter, Miss Carolyn Swanson, Atlanta; a son, James Swanson, with the armed forces; a sister, Mrs. Charles Roper, West Point. Funeral services were held in Hillview, LaGrange, with the Rev. Fred T. Kyle, rector of St. Mark's Episcopal Church, officiating.

RED CROSS IMMUNE SERUM GLOBULIN PLAN

Immune serum globulin (gamma globulin) for the prophylaxis, modification, and treatment of measles is now available for the civilian population through an appropriation by the American Red Cross as announced by Mr. Basil O'Connor, Chairman of the Central Committee of the American Red Cross. This action is in keeping with the policy of the American Red Cross to return to the American people, so far as practicable, any useful blood derivatives accumulated in excess of military needs as a result of its blood donor program.

The serum globulin will be supplied without charge to state and territorial health departments or local health departments where biologics are not supplied by the state, provided that the globulin will be distributed without charge to physicians, hospitals, and clinics, and provided that it will be administered in accordance with established standards and without any charge to the patient for the globulin.

As announced in the July 1, 1944, issue of the *Journal of the American Medical Association*, health departments assumed the costs of processing and distributing immune serum globulin. Under the new plan the entire cost of processing and distributing the product is now borne by the American Red Cross.

The crude serum globulin fraction thus made available is derived as a by-product from processing serum albumin under Navy control. It has been declared surplus and assigned by the Navy to the American Red Cross for distribution.

Eligible health agencies are being requested to place their orders promptly with National Headquarters, American Red Cross, Washington, D. C., attention of Dr. G. Foard McGinnes, National Medical Director.

REFRESHER COURSES FOR MEDICAL OFFICERS REASSIGNED TO PROFESSIONAL DUTY

Army medical officers who have been occupied with

administrative and other non-professional duties and who are to be assigned professional duties will be offered the opportunity to take refresher professional training under a new program just inaugurated by the Army Medical Department.

This training, which will be voluntary, will be open to members of the Medical Corps who, because of assignment to command, administrative or semi-professional positions have not engaged in the professional aspects of medical service during the past twelve months or more. Priority will be given those who have served overseas.

Requests for this training will be submitted through channels to the Surgeon General who will make assignments to the general and regional hospitals where the courses will be given. Officers selected will go on temporary duty for a period of not more than 12 weeks.

WANTED — Physicians for mental hospital; graduate class A school; experience in psychiatry desirable but not essential; salary and partial maintenance; near two excellent colleges. Address Box 325, Milledgeville, Georgia.

DIAGNOSIS AND SURGERY in DISEASES OF CHEST

Roentgenography, Fluoroscopy, Lipiodol
Bronchography, Bronchoscopy,
Esophagoscopy
Pneumothorax, Pneumolysis,
Thoracoplasty, Extrapleurals.

S. C. LYNN, M.D.

118 E. Jones St. SAVANNAH, GA.



UNSCENTED COSMETICS FOR THE ALLERGIC PATIENT

AR-EX Cosmetics are the only complete line of unscented cosmetics regularly stocked by pharmacies. To be certain that your perfume sensitive patients do not get scented cosmetics, prescribe AR-EX Unscented Cosmetics. SEND FOR FREE FORMULARY.

**FREE FORMULARY**

DR. _____

ADDRESS _____

CITY _____

STATE _____

AR-EX COSMETICS, INC., 6 N. MICHIGAN AVE., CHICAGO 2, ILL.



LONG LAST
Laboratory Tested

SURLES X-RAY CO.

Concentrated X-Ray Chemicals

34-11 56th Street Woodside, N. Y.

FASTER - LONGER LIFE - RICHER BLACKS - CLEARER WHITES - DOES NOT DROP OFF SUDDENLY

The Medical Profession will find it easy to control the quality of films with LONG LAST tested chemicals. LONG LAST will save money with its LONG LASTING qualities. Its speed will save time. Your dealer will supply you. Insist on LONG LAST. Circulars upon request. Available in 1 and 5 gallon sizes.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, June, 1945

Number 6

LEATHER-BOTTLE STOMACH

FRANK K. BOLAND, M.D.
Atlanta

The term "leather-bottle," suggested by Stretton in 1909, describes the condition of the stomach so well in these cases that it is used as the title of the present paper. Ewing calls the disease diffuse sclerosing fibrocarcinoma, and it is recognized that it may affect the intestines and other abdominal organs, so that reference to the stomach alone is inappropriate. Altogether more than forty-two different names have been proposed for the lesion. While the first case was reported by Andral in 1829, credit for the first complete account usually is given to Brinton¹ who, in 1854, published the results of autopsy findings, and applied the name by which the condition generally is known, *linitis plastica*, Greek for linen cloth or net.

The graphic picture given by Brinton has not been surpassed when he says, "The stomach, sometimes large, sometimes small, or perhaps of average dimensions, has a peculiar pearly whiteness and opacity; an appearance which is partly due to a dulness of the peritoneal coat in remarkable contrast with its ordinary mirror-like brilliancy. This change in color is found associated with the great increase in its weight and density; so that it has a hard, gristly feel, and not only fails to collapse by its own weight, but resists a considerable pressure; or returns to its original shape on the removal of such pressure like a large artery or rubber bottle. An incision through the coats of the organ exhibits a vast increase in its thickness." On opening the abdomen and encountering an example of

linitis plastica, one is impressed with the clearness and accuracy of this description.

Certainly the gross appearance of the leather-bottle stomach is very characteristic. Boyd believes that while the process probably begins at the pylorus, and extends from there, by the time the patient comes under observation the entire stomach usually is involved. The normal stomach is about 12 inches long and contains about 40 ounces, whereas the leather-bottle stomach may measure only 4 inches and contain 4 ounces. The wall may be as much as an inch thick. Boyd states that the thickening stops abruptly at the pyloric ring, and does not invade the duodenum. It is true, however, that other sections of the intestine, lower down, are affected. In most cases there is no pyloric obstruction; on the contrary, due to the stiff, open condition of the pylorus, barium leaves the stomach rapidly, furnishing an aid in x-ray diagnosis of leather-bottle stomach. The regurgitant vomiting seen in such cases may result from intestinal involvement.

In 1936 Dixon and Stevens² found that 235 cases of leather-bottle stomach among 11,000 operations on the stomach had been reported at the Mayo Clinic. Five of these cases involved the intestines. The total number of cases with intestinal involvement found in the literature at this time was 42. In one of the three patients described in this paper the small intestine apparently was affected with *linitis plastica* as well as the stomach; while in a second case the disease appeared to have spread to the small intestine, cecum and pancreas.

Report of Cases

Case 1—White woman, aged 52, who, in 1933, had been treated for bronchiectasis by postural drainage, with improvement. Later a cardiogram showed coronary sclerosis. In 1940 she began to have stomach symptoms, with epigastric pain, loss of appetite, anemia and weakness. Pain ensued after eating immediately, and she

¹Read before the Medical Association of Georgia, Savannah, May 10, 1944.



Figure 1
Leather-bottle stomach. Biopsy showed ulcer.

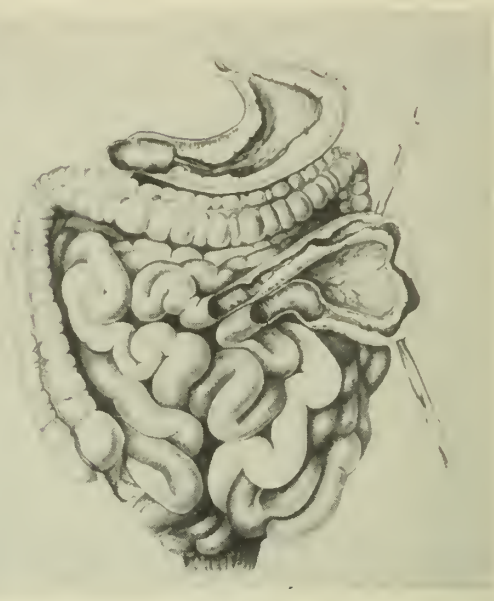


Figure 2
Diagram showing leather-bottle stomach with linitis plastica extending into intestine.

was able to swallow only small amounts of food. Nausea and vomiting followed, so that when seen in June 1942 she had lost considerable weight. Kahn test was negative; no analysis of stomach contents was made. X-ray showed a large lesion in the lesser curvature diagnosed as ulcer or carcinoma, and a movable mass was felt in the epigastrium. Through a midline incision, under sodium pentothal, the anterior wall of the stomach looked normal but the whole of the posterior wall was thick and unyielding presenting the appearance of linitis plastica. There was no metastasis in the liver or elsewhere. The anterior wall did not present the typical picture seen in the posterior wall, but was thicker than normal, and biopsy of a section was reported as ulcer. The patient's condition did not justify total gastrectomy. Jejunostomy was performed and the tube used for feeding until the patient insisted that it pained her and must be removed. At the present time, nearly two years after operation, the patient's status seems to be about the same as before operation. The mass in the epigastrium probably is larger, but x-ray shows practically no recent change. The patient is forced to eat five small meals a day.

Case 2—White woman, aged 39. Says she had "stomach trouble" ever since she was a child, worse during the past year. Gnawing pain one hour after eating, lasting until next meal; slight nausea, no vomiting. Lost weight recently, no anemia; Kahn negative. Noticed lump in upper abdomen nine months previously. X-ray showed mass in stomach, emptying in normal time. X-ray of gallbladder negative. Diagnosis: tumor of stomach, probably involving only one wall. Operation under sodium pentothal, Jan. 22, 1944, incision slightly to right of umbilicus. The entire stomach was involved in a mass which did not seem hard enough to be carcinoma. It felt like soft Moroccan leather and extended almost from the cardia to the pylorus, where it ended abruptly. The pancreas and cecum were similarly involved. The stomach was densely adherent to the transverse colon.

Only a few enlarged indurated glands were discovered. Biopsy was done from all involved areas, the pathologic report being chronic inflammation with fibrosis. All masses had the typical feel of linitis plastica. The patient's status at the present time is about the same as before operation, the mass seeming of similar size, and x-ray presenting the same picture. The case probably will terminate as one of carcinoma.

Case 3—White woman, aged 62. Past history included hysterectomy, thyroidectomy and a diagnosis of pulmonary tuberculosis. Did not know whether appendix was removed. During past few weeks had attacks of severe abdominal pain, now grown worse, and accompanied by distention, nausea, vomiting, and difficulty in having bowel movements. Following use of Wangensteen suction, and saline and dextrose intravenously, condition improved and patient went home. The diagnosis at this time was partial intestinal obstruction; the role played by the stomach was not recognized; no x-ray was taken. Two weeks later patient returned to hospital with pronounced stomach symptoms. Pain was severe and a mass could be felt to the left of the epigastrium. Gastrointestinal series showed a large filling defect in the stomach, with smooth outlines, suggesting a benign or luetic growth, although the diagnosis of the roentgenologist was carcinoma. Kahn was negative. Feb. 16, 1944, following blood transfusions, under sodium pentothal anesthesia, laparotomy revealed a thick tumor involving three-fourths of the entire stomach, and stopping abruptly at the pylorus. The mass did not have the hardness of carcinoma but felt like a typical leather-bottle stomach. The liver looked normal, and there were no involved glands in the area. While two or three segments of the small intestine showed the same thickened white condition, probably the cause of the previous attack of acute intestinal obstruction, there appeared to be sufficient sound tissue in the greater curvature of the stomach to make a Polya type of resection feasible, and

this was done. Laboratory diagnosis: carcinoma, grade 3. With the aid of transfusions the patient had a normal convalescence for several days, and then died suddenly, probably from embolism. No autopsy was done.

Apparently several different pathologic lesions may give the condition known as leather-bottle stomach, and shown in these three cases, one being diagnosed as inflammatory, another as ulcer, and another as carcinoma. All presented the white, glistening, thickened, rubber-like wall described by Brinton as linitis plastica. While Brinton thought the lesion was benign, he was not at all certain it was not malignant. Ewing and other authorities think more and more that all cases are malignant, which is hard to believe in a patient reported by Dixon and Stevens who still was living eleven years after a simple gastrojejunostomy; and another case reported by Lyle³ as cured by a similar type of operation.

Failure to recognize carcinoma in these cases may be due to the fact, first mentioned by Rokitsky a century ago, that the epithelial cells in scirrhus cancer of the stomach may be reduced to a minimum or may largely disappear, so that very careful microscopic examination is required to detect traces of the disease. As fibrosis increases in the growth, the tumor cells diminish in number, and in wide areas they may be difficult to demonstrate. Evidence of the epithelial structures may be lost over considerable areas of thickened submucosa and muscularis. Thus, diagnosis from complete autopsy specimens is more apt to be correct than diagnosis from small biopsy specimens.

Saphir and Parker⁴ believe that the linitis plastica type of carcinoma may be differentiated histologically from other types of carcinoma. "It is characterized by subacute and chronic inflammation with much fibrosis and hyalinization; by the presence of small darkly stained cells with little cytoplasm of small cells of low cuboidal shape with transitions to typical signet ring-shaped cells, and by miniature glandular structures." Metastasis to the liver is rare.

Preoperative recognition of leather-bottle stomach is rarely made. Lyle cited only two correct diagnoses in 126 cases. The

history usually follows other cases of gastric carcinoma. Roentgenologically, the stomach empties faster, and filling defects do not appear as ragged.

Very little is heard today of periodic annual examinations of apparently healthy persons after the age of forty. Such examinations probably were not extensive enough to detect disease in its incipency. Cancer of the stomach and colon are two of the most destructive diseases of mankind, and the only hope in curing them lies in their recognition early enough to make them amenable to radical surgical removal. There is a time in the history of most malignant lesions when the growth is small and localized, but large enough to be detected by thorough roentgenologic procedures in the hands of an expert. If it could be arranged, without excessive cost, that the periodic examination could include x-ray of the stomach and colon many cases of cancer could be diagnosed at a time when surgery could eradicate the disease completely, and thus reduce materially the death toll of this devastating malady.

BIBLIOGRAPHY

1. Brinton, William: *Lectures on the Diseases of the Stomach*, Philadelphia, Lea and Blanchard, 1865.
2. Dixon, C. F., and Stevens, G. A.: *Carcinoma of Linitis Plastica Type Involving the Intestine*, *Ann. of Surg.* 103, pp. 263-272 (Feb.) 1936.
3. Lyle, H. H. M.: *Linitis Plastica, with a Report of a Case Cured by Gastro-jejunostomy*, *Ann. Surg.* 14: 625-668 (Nov.) 1911.
4. Saphir, Otto, and Parker, Morris L.: *Linitis Plastica Type of Carcinoma*, *Surg., Gynec. and Obst.* 76: 206-213 (Feb.) 1943.

LASKER AWARDS

Dr. John MacLeod, of the Department of Anatomy, Cornell University Medical College, and Dr. Felix J. Underwood, executive officer of the Mississippi State Board of Health, received the 1944 awards of the Albert and Mary Lasker Foundation.

Presented at the 24th annual dinner meeting of the Planned Parenthood Federation of America, the awards were \$500 in cash, along with a plaque and scroll to each of the men. The presentations were made by Dr. Richard Pierson, New York obstetrician, chairman of the federation's medical committee.

Dr. MacLeod was cited "in appreciation of his years of basic research on the physiology of human fertility."

The award was given to Dr. Underwood in recognition of his state's expanded health program "including planned parenthood services as an integral part of the public health program of the State of Mississippi."

DIAGNOSTIC AND THERAPEUTIC USES OF PITUITARY EXTRACTS IN OBSTETRICS

R. A. BARTHOLOMEW, M.D.

Atlanta

Pituitary extract, a product of the posterior lobe of the pituitary gland, was introduced in 1909 by Blair Bell¹ in collaboration with Burroughs Wellcome & Co., who supplied the extract under the name of infundibulin. He particularly emphasized the value of the extract in obstetrics and in a subsequent communication² described in more detail the indications and contraindications governing its use in surgical and obstetrical practice. It was natural that an extract having such striking effects and practical uses should be the subject of a voluminous literature, dealing mainly with its stimulating effect on the uterine musculature in labor.

Failure to appreciate the powerful oxytocic effect of pituitary extract and the need of careful observance as to dosage and contraindications, have resulted in many cases of rupture of the uterus and asphyxiation of the fetus. These, in turn, have given rise to an attitude of over-conservatism which goes so far as to advise against or forbid use of the extract until after the baby has been delivered.

It would seem that the present-day attitude toward the use of pituitary extract in labor is to be found in either the one extreme, which ignores the possibilities of serious effects from overdosage, or in the other extreme which ignores the very real merits of the extract and admonishes against its use in labor under any circumstances.

It would, therefore, seem appropriate and timely to consider the various diagnostic and therapeutic uses of pituitary extract in pregnancy, labor, and the puerperium, by which the physician may, with safety, better serve the interests of both mother and baby.

Pituitary extract may be utilized as a valuable diagnostic aid in cases in which an ovarian cyst so closely simulates a gravid uterus, both as to location, size and con-

sistency and through concealment of the uterus itself, that a normal pregnancy of several months duration is mistakenly diagnosed. In other cases, two masses may be present, both having the size, shape, and consistency of a uterus of two or three months gestation, and of questionable continuity with the cervix.

The administration of four or five minims of pituitary extract subcutaneously will usually produce sufficient firmness of the questionable tumor within five to eight minutes to enable the examiner to differentiate the pregnant uterus from the cyst. A more rapid and positive reaction may be obtained by diluting two minims of pitocin in one cubic centimeter of sterile saline solution, and slowly injecting intravenously while bimanually palpating the questionable mass or masses. Pitocin rather than pituitrin should be used for intravenous injection, and produces contraction of the uterus within fifteen to twenty seconds.

In rare instances, later in pregnancy, there may be symptoms and findings which strongly suggest abdominal pregnancy. Administration of pituitary extract, as above described, will fail to produce any contraction of the mass since the fetus is enveloped solely in membranes and is not surrounded by uterine muscle.

Therapeutically, pituitary extracts may be made to serve many useful purposes from the early stages of pregnancy on through the puerperium.

Excessive bleeding during the progress of an inevitable abortion may be lessened and the expulsion of the products hastened by the subcutaneous administration of pituitary extract. It may also convert an incomplete into a complete abortion.

In the fourth month of pregnancy a retroverted pregnant uterus may occasionally fail to come forward spontaneously and threaten to become incarcerated in the pelvis. Attempts to replace it bimanually may fail, due to the fact that the soft elastic posterior wall of the uterus merely indents to the pressure of the fingers in the vagina, with no elevation of the uterus as a whole. I have found the use of pituitary extract very helpful in this condition, inasmuch as

digital pressure against a firm uterus is not only much more effective but the contraction produced may diminish the size of the uterus and better enable the fundus to pass the promontory of the sacrum. It also lessens trauma to the pregnant uterus and avoids the necessity of replacement under anesthesia.

In the latter part of pregnancy when toxemia or some other complication of pregnancy may require induction of labor, pituitary extract is a valuable adjunct to other procedures, such as introduction of a bougie, catheter or Voorhees' bag, or artificial rupture of the membranes. After the uterus has been sensitized by the reflex effect of a dose of castor oil, one or two minims of pituitary extract given subcutaneously at half-hour intervals may be successful in establishing labor. The possibility of producing too frequent, prolonged and severe contractions is much less when it is used to initiate pains, than when used to increase pains already established. The injections should be gradually discontinued after labor is definitely established,

It is in labor itself that pituitary extract serves most useful purposes if used wisely, but may produce the most serious effects if used without caution. The obstetrician should realize that there is a great variation in individual susceptibility to the subcutaneous administration of pituitary extract. The effect is less pronounced if the pains are already weak through the effect of primary inertia or anesthesia. If, however, frequent severe contractions are already established, or toxemia is present, even small doses may be distinctly dangerous and liable to cause rupture of the uterus, severe lacerations or intrauterine fetal asphyxia from stagnation of the retroplacental blood.

It is a noteworthy fact that a physician who shows the greatest respect for the limitations of dosage pertaining to other potent drugs, may show a most reckless unconcern as to the dosage of pituitary extract. Even though such radical therapy may result in rupture of the uterus, or intrauterine fetal death, this does not justify teaching that pituitary extract should never be used until after delivery. The penalty of such over-

cautiousness must be paid in operative injuries to the mother or baby, which could have been avoided by the judicious use of pituitary extract. In the presence of uterine inertia operative procedures such as cesarean section, cervical incisions or difficult forcep delivery may often be avoided by pituitary extract administered in the proper manner. In the presence of inertia there is no advantage in sparing the baby or mother, possible harmful effects from pituitary extract and inflicting comparable or worse damage through final resort to operative procedures.

Medical students or interns taught to shun pituitary extract during labor, do not maintain this attitude on entering practice. Observing the unrestricted use of pituitary extract by their fellow practitioners and impressed with its time-saving value, they use it freely thereafter, with no regard for contraindications or dosage.

If indication arises to use pituitary extract to induce labor or overcome uterine inertia, it is best to begin with intranasal administration, a method first proposed by Hofbauer in 1911.³ He recommended application by means of a cotton pledget placed in the nostril. I have found it preferable to instill three or four drops of pituitary extract into each nostril, the patient's head being alternately turned to the side and the nostril compressed to spread the solution over the mucous membrane. A definite increase in the frequency and strength of the contractions occurs within five to ten minutes and persists for thirty minutes or more. The dose may be repeated as often as the effect appears to subside. A rubber-stoppered vial furnishes the most convenient receptacle for dispensing the extract.

After more than ten years of experience with the intranasal method of administration, I can state that there has never occurred any evidence of over-action as determined by abnormally frequent severe pains, or slowing of the fetal heart rate. *It would be highly desirable if intranasal administration was universally substituted for subcutaneous injection, and the latter method restricted to the relatively few cases*

which do not respond to the intranasal method.

If the response to intranasal administration is insufficient, subcutaneous administration is then indicated, but it should be carried out with caution. The initial dose should not be more than one minim. If this amount is difficult to measure accurately in an ordinary syringe, a tuberculin syringe may be used. This dose seldom produces over-effect, and may be given at twenty to thirty minute intervals, gradually increasing to two or three minims per dose if necessary. If over-stimulation occurs, manifested by contractions occurring at one and one-half to two minute intervals, lasting sixty to ninety seconds and accompanied by increased tone of the uterus and slowing of the fetal heart below 100, a short period of inhalation of ether will slow the pains and restore the fetal heart to normal. It is often gratifying to observe the potentially serious aspect of a labor change to that of a normal delivery or a simple low forcep under this manner of treatment.

To facilitate final cleansing and draping of an amnesic patient for delivery, with no interference by restlessness, it has been found advantageous to induce light ether anesthesia when the head is about one-fourth crowned in nulliparae, or slightly visible in multiparae, and after performing episiotomy, if necessary, restore efficient pains and obtain spontaneous delivery by the injection of four minims of pituitary extract. Prerequisites are an ample outlet measurement and normal rotation of the head.

It is generally accepted that the administration of one-half to one cubic centimeter of pituitary extract immediately after the birth of the baby is both safe and desirable in that it favors separation of the placenta and lessens blood loss during the third stage. Ergotrate is generally considered superior to pituitary extract in maintaining a more prolonged state of contraction of the uterus after the third stage. Neither of these may be effective in preventing postpartum hemorrhage, if one neglects to express clots from the uterus before the patient is returned to her room.

There is perhaps no better example of

the value of prevention than in the treatment of postpartum hemorrhage. If the patient has had a prolonged labor with primary uterine inertia, a difficult operative delivery, an over-distended uterus, or prolonged anesthesia, one should be forewarned of the probability of atony and increased hemorrhage during or after the third stage. In pitocin we have a most efficient agent, which, if prepared in advance, may be given intravenously in the amount of three or four minims. It may be administered immediately after birth of the baby, or held in reserve to be given promptly if bleeding is excessive. In fifteen to twenty seconds the uterus becomes rigid and bleeding completely controlled. Ergotrate may also be used in this manner but it is generally admitted that retention of the placenta is more apt to occur.

Pitocin serves another valuable use in controlling bleeding during cesarean section. If intravenous injection of glucose or saline solution is begun at the time of operation, three or four minims of pitocin may be injected through the rubber tubing near the needle at the moment of incising the uterus, and may be repeated at intervals of ten or fifteen minutes during the operation to insure the maximum state of contraction of the uterus and thus conserve blood during the repair.

Finally, if after delivery the uterus is found distended from concealed clots and hemorrhage, pitocin may be used intravenously to facilitate expulsion of the clots and combat low blood pressure and syncope. Ergonovine should also be used. Pituitary extract may also be used to combat urinary retention and tympanites during the early days of the puerperium.

Conclusions

1. Diagnostically, pituitary extract may be used to differentiate pelvic tumors which may simulate a pregnant uterus, and also to aid in the diagnosis of abdominal pregnancy.

2. Therapeutically, pituitary extract is of value in abortions; in digital correction of a retroverted pregnant uterus threatened with incarceration in the pelvis; in induc-

tion of labor; in the treatment of uterine inertia during labor; in the prevention of excessive blood loss during or after the third stage of labor, and during cesarean section. It may also be of value in the prevention of postpartum retention of urine or tympanites.

3. Pituitary extract may be used with complete safety to combat uterine inertia during labor if given by intranasal instillation, and will give satisfactory increase in contractions in a great majority of cases.

4. Universal adoption of the intranasal method should supplant the subcutaneous method of administration of pituitary extract before delivery of the baby.

5. In the relatively few cases in which pituitary extract does not give sufficient stimulation by the intranasal method, it may be used subcutaneously with negligible risk, if the initial dose is not more than one minim and the effect on the contractions and the fetal heart is carefully observed.

6. There is no advantage in abstaining from the use of pituitary extract in the treatment of uterine inertia during labor and incurring as great or greater risk to the mother and baby in final resort to major operative procedures.

7. Medical students and interns should be taught the proper use of pituitary extract in labor to better assure the greatest measure of safety to the mother and baby, rather than to follow a policy of extreme conservation or radicalism.

REFERENCES

1. Bell, Blair: The Pituitary Body, *Brit. M. J.* p. 1609, (Dec. 4) 1909.
2. Bell, Blair: An Address on Infundibulin—The Indications for its Use in Surgical and Obstetrical Practice, *Brit. M. J.* p. 1027, (June 6) 1925.
3. Hofbauer, J., and Hoerner, J. K.: The Nasal Application of Pituitary Extract for the Induction of Labor. *Am. J. Obst. & Gynec.* no. 2, p. 137 (Aug.) 1927.

DENTAL NEEDS OF RETURNED SOLDIERS

A redistribution station in this country, where soldiers just returned from overseas receive dental treatment, has reported to the Office of the Surgeon General that about one man in ten needs an extraction or other emergency dental treatment. This includes the construction of a denture if the man hasn't enough teeth to chew an average meal. According to this report, about 45 per cent of the men returning from overseas need one or more fillings while about 40 per cent do not require any dental treatment. Figures previously released by the Dental Division, Office of the Surgeon General, show that about one man in every four requires emergency dental treatment at the time of induction.

TUBERCULOSIS: WHOSE THE BURDEN?

H. C. SCHENCK, M.D.

Division of Tuberculosis Control
Georgia Department of Public Health
Atlanta

The question can be answered easily and with certainty. It is the burden of the people, for they must bear the expense and the misery and the deaths which come in very great measure because of this disease which they permit to exist. There is hardly a community in the United States in which there is not tuberculosis, in which there are not communicable cases, in which there is not a large percentage (50 per cent or more) of the population that has been infected as shown by mass tuberculin testing, and in which many deaths from tuberculosis have not occurred. It was announced recently that 191,000 members of our armed forces have been killed since Pearl Harbor. During the same period more than 200,000 persons in the United States have died of tuberculosis. Many other war casualties, wounded and disabled have occurred—these are matched by tuberculosis in crippling and disabling to as great an extent.

It is implied in the opening sentence that the people permit tuberculosis to exist. Do the people have anything to do with permitting or not permitting the perpetuation of this disease? What can they do to stop it? If they can have tuberculosis wiped out and neglect doing it, have they not become actually responsible for all of the suffering and dying that has resulted from it? They surely are responsible because since the discovery by Koch sixty-five years ago that infection by tubercle bacilli is the cause of tuberculosis it has been possible to prevent it. If vigorous preventive measures had been boldly undertaken, by this time the disease could have been practically eliminated. It was not done, simply because those who had the power were not interested enough to spend the money for the all-out fight which was necessary to bring about victory. Today there is a similar tendency not to spend enough for facilities fully adequate for control of tuberculosis and to expect too much of those charged with the control of disease but not provided with adequate means. The people can stamp out tuberculosis in a comparatively few years if they wish to pay the price. They may be assured, however, that the price they will unknowingly pay to allow tuberculosis to remain will be more than that required to get rid of it. Georgia had 1,305 deaths in 1943—1944 figures are not yet available, but provisional figures are less than for the same period in 1943, and nearly 3,000 cases were reported in the same year. It has been estimated that the cost of tuberculosis to a community is roughly \$10,000.00 per annual death, or \$4,000.00 per reported case. Figuring either way the annual

cost of tuberculosis in Georgia is \$12,000,000.00 or more. If the expenditure of this money or of half of it could be directed systematically toward tuberculosis control, this disease in a few years could be relegated to relatively small importance.

The Health Department and Tuberculosis

The Georgia Department of Public Health has always been mindful of the need for vigorous action against tuberculosis. It has been repeatedly pointed out for many years the steps that must be taken, the methods that must be pursued, the facilities which must be provided, if tuberculosis is actually to be brought under control. And, although these facilities have not been made available, the Health Department has gone ahead without them and fought the best it could against this enemy which never gives quarter. Let us look into the record and the history of tuberculosis in the State.

In the year 1930, the situation was approximately this: The deaths from tuberculosis numbered 2,175, and only 879 cases were reported. There were no field x-ray or diagnostic clinics, local clinics were almost unknown, pneumothorax and other lung collapse measures were rarely done outside of sanatoria, and to a very limited extent in them. Only about 300 patients could be taken care of at the State Tuberculosis Sanatorium and 336 in city and county sanatoria. Comparatively little chest x-ray service was available. Follow-up of contacts, breaking of contacts and preventive measures were all of inferior order. And although few cases could be admitted to sanatoria not much attention was directed to care of patients in their homes. In fact, judging by the excess of deaths over cases reported, diagnosis was made more often at the time of death, or after death than long enough before death to permit anything to be done for the patient or to prevent the serious infection of his family and close associates.

In an effort to remedy this intolerable situation the State Health Department has taken a number of important steps. In the fall of 1930 a field chest consultation clinic service was begun in a few counties having full time health commissioners. A clinician from the State Tuberculosis Sanatorium and a clinic organization nurse loaned by the State Tuberculosis Association formed the State unit. Later a portable x-ray machine and x-ray technician, another clinician and nurse were added. Within a year about fifty counties were given the benefit of this service at the request of the local medical societies. These clinics were popular from the start with the medical profession and the people generally. Case finding improved to such an extent that by 1934 over 3,000 new cases were being reported annually, and reporting of new cases has remained at this fairly high figure in spite of the fact that the number of deaths and death rate

have been cut nearly in two. The majority of new cases are now located and reported by practicing physicians and local health departments and the State Health Department is pardonably proud of its part in this development.

Shortly after the commencement of field diagnostic aid the idea was conceived by members of the State Health Department of offering training at the State Tuberculosis Sanatorium at Alto to physicians interested in giving artificial pneumothorax to ambulant patients so that their stay in the Sanatorium could be shortened. Over a hundred physicians responded to this offer and today over sixty physicians are giving this treatment outside of sanatoria. The State Health Department has an arrangement with most of these physicians for payment of nominal fees for this service to patients who have been certified by county welfare directors as unable to meet the cost personally. Over 500 cases are receiving this service at an annual cost of about \$25,000.00. In these instances it may be said that the Sanatorium is brought to the patient. Or it may be pointed out that through this service more patients are getting a type of treatment formerly rarely given outside of sanatoria than are now being treated at Alto. In addition to this, every possible effort is being made to promote assistance, medical and otherwise, to thousands of cases in their homes and communities, to have thousands of contacts and suspects examined, to promote rehabilitation of patients and education of the masses concerning the nature, prevention, diagnosis and treatment of tuberculosis. Below is a partial list of tuberculosis services rendered by local health departments in 1944:

Cases admitted to service.....	3,752
Contacts admitted to service.....	13,194
Suspects admitted to service.....	6,707
<hr/>	
Total individuals admitted to service....	23,653
Total field visits to above.....	55,526
Total office visits of above.....	25,061
Admissions to sanatoria secured.....	560
Number of tuberculin tests given.....	22,322
Contacts broken	1,522
Tuberculosis cottages built.....	18

In addition to these services by local health departments, the State Health Department, in spite of serious personnel difficulties and difficulties in obtaining equipment, repairs and supplies, participated as follows:

Interpreted and reported in 1944:

Field x-ray clinic pictures.....	10,232
Central office x-rays.....	325
Consultation x-rays sent in by physicians	4,264
Photo-fluorographic 35 mm. pictures.....	15,552
<hr/>	
Total	30,373

Eight hundred and forty-six new cases of tuberculosis were located by this means.

Since 1930 the bed capacity of the State Tuber-

culosis Sanatorium has been nearly doubled while that of the local institutions has changed little. A great expansion of both case-finding and of treatment facilities are needed. A thousand or more institutional beds should be made available as rapidly as possible. More are probably necessary, but a thousand would be of enormous help. The State Health Department has on order six photo-fluorographic machines and other equipment for mass case finding. These are to be put into use as soon as delivery can be had and personnel can be secured. This expansion is made possible through Federal funds matched against State funds. No such aid is yet available for tuberculosis sanatoria. It is believed they will be provided and the State should be ready to take advantage of the offer when it does come.

The people can have tuberculosis control when they will it enough to make it possible. The State Health Department is ready; its plans are ready to assist in many and large ways. All it needs is the money. It has the vision. None but the people have the power to make possible the consummation of these plans. They and they only can make victory possible in a few years.

SOVIET MEDICINE

"Blood Symposium" is the leading series of articles among the numerous clinical and experimental translations in the February 1945 issue of the *American Review of Soviet Medicine*.

The early study of blood transfusion originated in the Soviet Union. The current research published here emanates from the Central Institute of Hematology and Blood Transfusions in Moscow. Professor Alexander A. Bogomolets whose work has previously appeared in this journal as the author of the work on the antireticular cytotoxic serum, is a consultant at the Central Institute. In his article entitled, "Blood Transfusion in the Treatment of Internal Disease," Bogomolets presents a new approach to the action of blood transfusion and its stimulating influence on the organism through his analysis of colloidoclasia and the formation of autocatalysts.

V. I. Kasanski, the author of two articles in this series, discusses the preservation of erythrocytes for as long as twenty-one days in a special formula offered. In his report on frozen plasma, which is thawed directly before use, he states that "the therapeutic effect of transfused, thawed blood plasma is the same as that with fresh plasma. Thawed plasma may be used for the same diseases and in the same doses as fresh blood." The efficacy of blood transfusion in military practice, as well as in infectious diseases as described by A. A. Bagdasarov, substantiates the studies made at the Central Institute.

In a group of other articles published in this

journal, the pathogenesis, physiotherapy and treatment of wound healing are reported. The authors maintain that wound healing can be accelerated if the selected therapeutic agent is applied at the proper stage of healing. The articles deal with the use of irradiation, emulsion of embryonal extracts, and ammonium bicarbonate. The latter was introduced into American clinics at first, and the Soviet physicians later applied its use in Ashkabad in 1942 with success.

In addition to a profile of N. F. Gamaleya, the father of microbiology written by Yuri I. Milenushkin, a senior operating nurse contributes an article entitled "Intravenous Alcohol Anesthesia" as practiced at the N-Evacuation Hospital.

EXPECTATION OF LIFE STUDIED AT DUKE UNIVERSITY

Hornell Hart and Hilda Hertz of the Department of Anthropology, Duke University, have made their first report on studies on expectation of life as an index of social progress.

They have found that the average expectation of life at birth in seven Euro-American countries increased from 41.06 in 1840 to 61.70 in 1930, an increase of 50.3 per cent in 90 years. The seven countries for which data are available are the United States (represented by the state of Massachusetts), Denmark, England and Wales, France, Netherlands, Norway, and Sweden.

Government efficiency and honesty, they report, are reflected by high expectations of life. Where governments are corrupt, badly organized and inefficient, the health departments and hospitals are likely to be failing in their tasks, while the water and milk supplies are likely to be contaminated by disease-bearing bacteria. Good health and low death rates reflect a well-educated and informed public, they conclude.

High expectation rates reflect good working conditions, long life, relative freedom from bereavement, health, high scale of living, efficient government, and effective education, they have found.

These two anthropologists have further deduced that the trend of urban expectation of life has been much more steeply upward than that of rural areas; and, also, if expectations derived from prehistoric skeletons and from ancient tombstones are even approximately correct, expectation of life has increased as much since 1800 as it did during the preceding 50,000 years.

Hart and Hertz see expectation of life at birth increased to between 69.14 and 72.28 years, and conclude that:

"To accept 70 to 75 years as an ultimate limit, however, would be to assume that the span of human life has an inherent maximum which it is impossible for science to transcend. If and when cancer is conquered, if and when the reasons are discovered for aging organisms made up of cells which under favorable conditions remain immortally young, if and when new basic discoveries like these are made, we may expect new and more sweeping upsurges in life expectancy."

RELAPSING SYPHILIS AFTER INADEQUATE PENICILLIN THERAPY

HUGH HAILEY, M.D.

Atlanta

With the increase in supply of penicillin, its relative harmlessness and its effectiveness in a large and varied number of diseases, physicians will likely use it often. Therefore, it is considered worthwhile to recall that a dosage sufficient to cure gonorrhea or impetigo will only mask and delay a syphilitic infection.

The following case is reported:

R. C., white male, aged 27, developed a sore on the penis in December, 1944. Examination, as recorded in his health record, described an ulcer with swelling of the prepuce and a generalized eruption diagnosed as impetigo. Treatment consisted of 200,000 units of penicillin by intramuscular injection in a period of two days, plus local penicillin solution compresses to the penile lesion. When all evidence of the eruption had disappeared the patient was discharged to duty.

In March, 1945, the rash began to reappear. When a second series of penicillin injections failed to cure him he was transferred to a naval hospital ship. On this occasion he presented a generalized ham colored papular eruption with dark red lesions of the palms and soles. The prepuce and glans showed numerous split pea sized deep red papules. Repeated blood Kahns were positive. After two weeks of mapharsen and bismuth injections all lesions had healed except for residual pigmentation, the patient then being discharged to duty under treatment.

In the tropics it becomes necessary sometimes to employ penicillin to cure obstinate cases of impetigo, but in this instance it appears that the penile lesion must have been spirochetal instead of pyogenic.

The experience in this case points out the value of having blood Kahn and dark field examinations when there may be doubt about the clinical diagnosis.

GEORGIA'S DEPLORABLE SYPHILIS RATE

Those members of the recent general assembly who, because of petty politics, blocked plans to give Georgia a more adequate program of public health are hereby referred to the most recent statistics on the incidence rate of syphilis as reported by Selective Service examiners.

These statistics, compiled from reports of induction stations throughout the nation, show that only two states—Mississippi and Florida—have higher syphilis rates than Georgia among all men examined, black and white, and that Georgia has the worst record of all among the whites.

An average of 145.9 among each 1,000 Georgians examined were found to be infected—as against, for example, 4.8 in New Hampshire, 5.8 in North Dakota, and 6.2 in Wisconsin.

Thirty-two of each 1,000 white inductees examined from Georgia had syphilis and the startling total of 302.4 of every 1,000 Negroes examined were similarly infected.

Syphilis, in such deplorable proportions, is a constant drain on Georgia's productive capacity. It contributes to indolence and poverty at best and crime and insanity at worst.

Yet syphilis, under a comprehensive program of public health, can virtually be eradicated at relatively small cost. Progressive Glynn county, right here in Georgia, is irrefutable evidence of that.

Georgia's syphilis rate is a shame to a state which likes to think of itself as civilized. The sooner we undertake an unrelenting campaign to stamp it out, the better.—*The Atlanta Constitution*, April 28, 1945.

FIVE MORE TROOP SHIPS TO BE CONVERTED TO HOSPITAL SHIPS

Five more troop ships are being stripped of their armament and converted into United States Army hospital ships in order to insure speedier return of America's combat wounded.

The addition of these new ambulance-type hospital ships will bring the number of hospital ships operated by the Army up to 29 with facilities for transporting more than 18,000 sick and wounded.

Conversion of the new ships, which together will be able to carry 5,355 patients, will be completed in about four months. They will be painted white with red crosses and green bands—which insures protection under the Geneva Treaty—and will be ready for service by June or July.

The *Saturnia*, with a speed of 19 knots and gross tonnage of 24,470, will be the largest and fastest hospital ship afloat. A former Italian luxury liner, built at Trieste, Italy, in 1937, she is 630 feet long and will have a capacity of 1,300 litter and 388 ambulatory patients.

The other vessels slated for conversion are the former French liners *Columbie*, with a capacity of 608 litter and 172 ambulatory patients, and *Athos II*, which will carry 615 litter and 264 ambulatory cases; the former United States liner *Republic*, with a capacity of 900 litter and 300 ambulatory patients; and the *President Tyler*, with a capacity of 650 litter and 158 ambulatory patients.

Two other Army vessels now are under conversion as hospital ships. They are the *Ernestine Koranda*, named for an Army nurse, and *Louis A. Milne*, named for a former New York Port surgeon.

THE SCHOOL-CHILD'S BREAKFAST

Many a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, small wonder that he is listless, nervous, or stupid at school. A happy solution to the problem is Pablum. Pablum furnishes protective factors especially needed by the school-child—especially calcium, iron and the vitamin B complex. The ease with which Pablum can be prepared enlists the mother's cooperation in serving a nutritious breakfast. This palatable cereal requires no further cooking and can be prepared simply by adding milk or water of any desired temperature.—MEAD JOHNSON & COMPANY, EVANSVILLE, IND.

THE PRESIDENT'S PAGE

WILLIAM A. MULHERIN, M.D.

*"A mighty cedar has fallen, leaving a lonely place
against the sky."*

The Medical Association of Georgia has suffered a greivous loss in the recent death of Dr. Will Mulherin; a loss that cannot be estimated because the count would be in terms of loyalty, loving kindness, high purpose and all of those intangible verities that motivate fine comradeship and accomplishment.

There is nothing I can say that would add an honor to the many that he accumulated during his full life, but there is a certain satisfaction and inspiration in contemplating the lovable qualities of the man, which he projected into his profession. It is especially gratifying to pay tribute to his loyalty and devotion to the Medical Association of Georgia. There were few of the state meetings which he ever missed, and few of its projects that he did not indefatigably work for. During his presidency in 1927-28, the records show that he devoted himself to great tasks. He was

honored far beyond the limits of the State: once being chairman of the pediatric section of the American Medical Association, and for more than twenty-five years the inspiration of the Pediatric Clinic at Saluda, N. C.

He was a good speaker with genial personality, pleasing voice, scholarly perspective and, above all, a sympathetic outlook. He was as gentle as a child, and as unassuming. He was too big to do a little thing, but not too big to find an approach to the limited and prejudiced. He was big enough to appreciate other doctors, and hundreds were inspired and encouraged by his warm "You did a splendid job; that is just fine."

He kept the confidence and esteem of the doctors, his patients, and his friends. He had a culture and chivalry that were not exterior but emanated from an honest mind and warm heart. He kept the spirit as well as the letter of Hippocratic ethics: they were the whole of him. We shall miss Will Mulherin sadly through the years.

CLEVELAND THOMPSON, M.D.



THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

JUNE, 1945

LONGEVITY OF THE AMERICAN PEOPLE IN 1943

The average length of life of the American people in 1943, as computed from the mortality then current, was 64½ years, or only one-third of a year less than the peak reached in 1942, said the *Statistical Bulletin* of the Metropolitan Life Insurance Company for April, 1945. These figures reflect the experience of the entire population within the United States, both civilian and military, but the data exclude the experience among men and women beyond the borders of our country.

"The slight setback in longevity during 1943 was due in large measure to the high toll taken by the influenza epidemic which swept the country toward the close of that year. Two other factors played a major role in reducing the average length of life of the resident population, particularly among white males, during our second full

war year. In the first place, very large numbers of the healthiest males at the prime ages of life were withdrawn for service overseas in 1943, so that they were excluded from the experience. Secondly, among the young men still in the country there was a sharp rise in mortality from accidents, especially in connection with military aviation. As a result, the average length of life of white males on the basis of mortality conditions in 1943 was reduced to 63.16 years, one-half year less than in 1942. For white females with an average of 68.27 years, the corresponding reduction was only one-third of a year. Comparable data for earlier years are shown in Table 1.

"Among colored persons the change in experience from 1942 to 1943 was more favorable than among the white. Colored males, with an average of 54.65 years in 1943, gained almost two-fifths of a year, while the figure for colored females remained practically unchanged at 58 years.

"So slight was the setback in 1943 for the population as a whole that the record for the year still compares very favorably with that for prewar years. The average length of life (expectation of life at birth)

TABLE 1—EXPECTATION OF LIFE AT BIRTH AND AT AGE 40 IN THE UNITED STATES, ACCORDING TO COLOR AND SEX, FOR SELECTED PERIODS FROM 1900 TO 1943

YEAR OR PERIOD	BIRTH				AGE 40			
	WHITE		COLORED*		WHITE		COLORED*	
	Males	Females	Males	Females	Males	Females	Males	Females
1943†	63.16	68.27	54.65	57.97	29.97	33.47	25.83	28.11
1942†	63.65	68.61	54.28	58.00	30.27	33.86	25.92	28.51
1939-1941†	62.81	67.29	52.26	55.56	30.03	33.25	25.06	27.19
1930-1939†	60.62	64.52	50.06	52.62	29.57	32.24	24.65	26.11
1929-1931†	59.12	62.67	47.55	49.51	29.22	31.52	23.36	24.30
1920-1929†	57.85	60.62	46.90	47.95	29.35	30.97	24.55	24.67
1919-1921†	56.34	58.53	47.14	46.92	29.86	30.94	26.53	25.60
1909-1911§	50.23	53.62	34.05	37.67	27.43	29.26	21.57	23.34
1901-1910§	49.32	52.54	32.57	35.65	27.55	29.28	22.23	23.81
1900-1902§	48.23	51.08	32.54	35.04	27.74	29.17	23.12	24.37
Gain 1900- 1902 to 1943	14.93	17.19	22.11	22.93	2.23	4.30	2.71	3.74

NOTE—The life tables for 1943 and 1942 were prepared in the Statistical Bureau of the Metropolitan Life Insurance Company, that for 1943 being on the basis of unpublished data furnished by the United States Census Bureau.

*Data for periods from 1900 to 1931 and 1939 to 1941 relate to Negroes only.

†Continental United States.

‡Registration States of 1920.

§Original Death Registration States.

in 1943 was three-quarters of a year above the figure for 1940, five years better than that for 1930, and $15\frac{1}{4}$ years greater than the average at the beginning of the century. The gain since 1900 was greater for females than for males, and more pronounced for colored persons than for the white. The increases were: white females, 17.19 years; white males, 14.93; colored females, 22.93; and colored males, 22.11 years.

"Changes similar to those noted for the expectation of life at birth are found also at a wide range of ages. Data for age 40

are expected to survive to age 32, among white females the same proportion will live to 43 years.

"Longevity among colored lives still lags substantially behind that for white persons. For example, the average length of life for the colored in 1943 was less than that for white persons in 1919-1921. In 1943 the expectation of life at birth for colored persons was about the same as that for white persons 13 years of age. Similarly, nine out of ten of the colored males will survive from birth to age 16,

TABLE 2—EXPECTATION OF LIFE AND MORTALITY RATE PER 1,000, AT SPECIFIED AGES, BY COLOR AND SEX, GENERAL POPULATION IN THE UNITED STATES, 1943*

AGE	EXPECTATION OF LIFE					MORTALITY RATE PER 1,000				
	Total Persons	WHITE		COLORED		Total Persons	WHITE		COLORED	
		Males	Females	Males	Females		Males	Females	Males	Females
0	64.50	63.16	68.27	54.65	57.97	41.06	42.30	32.91	69.72	56.58
1	66.24	64.93	69.57	57.71	60.42	4.01	3.77	3.37	7.37	6.45
2	65.51	64.17	68.81	57.13	59.80	2.29	2.33	1.88	3.64	3.25
3	64.65	63.32	67.94	56.34	59.00	1.68	1.74	1.41	2.43	2.17
4	63.76	62.43	67.03	55.47	58.12	1.32	1.35	1.13	1.95	1.69
5	62.85	61.51	66.11	54.58	57.22	1.11	1.16	.96	1.59	1.35
10	58.13	56.82	61.35	49.91	52.50	.79	.89	.61	1.13	.89
15	53.39	52.10	56.55	45.29	47.84	1.28	1.39	.84	2.66	2.40
20	48.80	47.55	51.82	41.04	43.58	2.17	2.62	1.23	4.67	4.34
25	44.36	43.21	47.16	37.07	39.57	2.56	2.96	1.55	5.90	5.19
30	39.91	38.79	42.53	33.17	35.60	2.77	2.77	1.91	7.07	6.10
35	35.48	34.34	37.96	29.40	31.75	3.56	3.44	2.53	9.18	8.05
40	31.16	29.97	33.47	25.83	28.11	4.93	4.96	3.41	12.18	10.72
45	26.99	25.79	29.09	22.50	24.68	7.11	7.54	4.93	16.75	13.87
50	23.03	21.87	24.87	19.55	21.54	10.51	11.59	7.26	23.95	20.03
55	19.33	18.24	20.84	17.02	18.87	15.17	17.26	10.68	30.31	26.93
60	15.89	14.93	17.05	14.62	16.50	22.17	25.67	16.55	35.85	33.45
65	12.77	11.98	13.58	12.35	14.40	32.95	37.84	26.28	47.56	43.05
70	10.01	9.37	10.51	10.48	12.63	48.86	55.30	41.54	62.93	51.79
75	7.58	7.09	7.84	8.84	10.91	72.57	81.02	65.80	72.31	57.56
80	5.53	5.17	5.64	7.02	9.06	114.83	126.95	108.95	88.47	68.70

*Computed in the Statistical Bureau of the Metropolitan Life Insurance Company, on the basis of unpublished data furnished by the United States Census Bureau.

are shown, by way of example, in the right-hand panel of Table 1. Although each race and sex group at this age experienced a slight setback in expectation of life from 1942 to 1943, all of them show a decided improvement as compared with 1900.

"The details of the life table for 1943, which is shown in abridged form in Table 2, present some noteworthy features. The expectation of life for white girls 8 years old is just as great as that for newly born white males. The superior longevity of females is also evident from the fact that, whereas nine out of ten white male babies

and a like proportion to age 21 for colored females; these ages are only half the corresponding ages observed above for white males and females.

"The mortality rates in the right-hand panel of Table 2 show further evidence of the handicap of the colored as compared with the white population. For the wide range of ages from 16 to 42 years, the mortality rates for colored females were fully three times those for white females, while from ages 43 to 60 the rates were twice as great. At ages 12 to 15 also, colored girls were subject to a mortality

double that for white girls. Among males the rates for the colored were at least twice those for white lives from ages 26 to 51. The facts clearly indicate that there is substantial room for improvement in the mortality and longevity of the colored population.

"There are indications, from provisional data available so far, that in 1944 the American people had recovered, in part, from the setback which they experienced during 1943, and that the situation so far in 1945 is also favorable. Our Nation has been singularly fortunate that its civilian population has escaped the ravages of war, with its attendant misery, want, and death. As the war in Europe draws to a close, the prospects are good for continued improvement in longevity."

V-E DAY MEANS BIGGER TASK FOR ARMY MEDICAL DEPARTMENT

The ending of hostilities in Europe means that the doctors, nurses, technicians and other personnel who comprise the Army Medical Department will now begin an even bigger job than they have been doing which means there is no immediate prospect for the general release of personnel, Major General Norman T. Kirk, the Surgeon General, declared on V-E Day.

The Medical Department, he pointed out, not only must continue to care for the sick and wounded but must make immediate preparations for the redeployment of troops to the Pacific or this country.

One of the biggest tasks will be to give physical examinations to some 3,500,000 soldiers before they leave Europe. In addition, a goal of 90 days has been set in which to evacuate the sick and wounded from the European Theater to this country. Then there will be the final matter of redeploying the Medical Department personnel and equipment.

Soldiers whose condition necessitates a medical discharge will be given further treatment and necessary examinations in the United States. All soldiers, prior to discharge from the service, will be screened for tuberculosis, syphilis and other diseases, and for possible strains and other physical defects. Thus hospitals here will probably be operating at capacity with a critical need for medical personnel for many months to come.

"Practically all officers and men in the Medical Department came in for the emergency," said the Surgeon General, "and so far as we are concerned the emergency is far from being over."

NATIONAL HOSPITAL DAY 1945 FINDS "HOSPITALS FIGHT ON TWO FRONTS"

Fighting on two fronts, civilian hospitals celebrated National Hospital Day 1945 on May 12 in a nation requiring their services abroad and at home. Their record to date: 54,000 hospital-trained nurses and 60,000 hospital-trained doctors plus many thousands of technicians serving our fighting men in the services; and the admission of over 12 per cent of the American population to community hospitals in 1944—one every two seconds—for civilian hospital care.

"The past year has seen an increase of almost a million patients admitted to the hospitals of this country," stated Dr. Donald C. Smelzer, president of the American Hospital Association, in announcing May 12 commemorations by hospitals over the country. "Despite a decrease in the total number of voluntary hospitals, the bed capacity in them has actually grown by several thousands. Shortages of personnel and difficulties in obtaining supplies, added to this increased demand for hospital care, have necessitated patience and understanding on the part of administrators and the community as well.

"May 12, the 125th anniversary of the birth of Florence Nightingale who initiated modern hospital practices, nevertheless finds the 3500 voluntary hospitals in the Association aware of increased public interest in hospital care and making plans for expansion and improvement. As agents of society, community hospitals must keep pace with the desires of that society. The nationwide analysis of hospital facilities by the independent Commission on Hospital Care, the contemplated billion dollar expansion plans of hospitals, the rapid extension of hospital-sponsored, non-profit Blue Cross prepayment plans for hospital care, as well as the vital role played by hospitals in the health care of our men in uniform—all give conclusive proof that hospitals, on National Hospital Day, are worthy of the nation's support and interest."

"EYE BANK" ELECTS OFFICERS

Formation of The Eye Bank for Sight Restoration, Inc., which will collect and preserve healthy corneal tissue from human eyes for transplanting to blind persons who have lost their sight because of corneal defects, was announced recently. The organization, national in scope, has been incorporated under the laws of New York State and 22 leading hospitals in New York City are now affiliated with it; in addition, 20 outstanding ophthalmologists throughout the country will serve in an advisory capacity. Headquarters are at 210 East 64th Street, New York City.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.
 Corresponding Secretary—Mrs. Alex Russell, Winder.
 Treasurer—Mrs. Ralph Fowler, Marietta.
 Historian—Mrs. W. W. Puett, Norcross.
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.
 Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

The Woman's Auxiliary to the Glynn County Medical Society met recently at the home of Mrs. W. C. Thomas on Sea Island. Mrs. T. V. Willis, president, presided. This auxiliary is very young, having completed its first year and plans were outlined for the coming year. The following officers were elected:

President—Mrs. T. V. Willis
 Vice-President—Mrs. W. C. Thomas
 Treasurer—Mrs. J. W. Simmons
 Secretary—Mrs. C. B. Greer
 Corresponding Secretary—Mrs. Howard M. Coe
 Hygeia Chairman—Mrs. L. C. Mitchell
 Publicity—Mrs. R. S. Burford

The Woman's Auxiliary to the Randolph-Terrell Medical Society held the last meeting of their fiscal year April 27 at the home of Mrs. W. G. Elliott in Cuthbert. Mrs. L. R. Massengale, president, presided. Annual reports from standing committees were heard. Mrs. Harper, vice-president, presented a beautiful tribute to our late beloved President, Franklin Delano Roosevelt.

It was moved and passed that the first meeting of year 1945-46 be held the first Friday night in May, the same hour the doctors meet, and that we submit county auxiliary reports to the state chairmen to be filed with the state officers.

At the May meeting of the Auxiliary to the Fulton County Medical Society, presided over by Mrs. John W. Turner, president, the nominating committee presented the following slate of officers:

President—Mrs. D. R. Longino
 President-elect—Mrs. Hal Davison
 First Vice-president—Mrs. Olin S. Cofer
 Second Vice-president—Mrs. Frank K. Boland
 Third Vice-President—Mrs. Homer R. Maulding
 Secretary—Mrs. Bolling Gay
 Treasurer—Mrs. Hartwell Boyd
 Corresponding Secretary—Mrs. Emory Lower
 Historian—Mrs. Dan Sage
 Parliamentarian—Mrs. W. A. Selman
 Auditor—Mrs. John Turner

Dr. and Mrs. Ben Hill Clifton, whose marriage was a recent event, were honor guests at a reception at the Fulton County Academy of Medicine, Wednesday evening, May 16, from

8:30 to 10:30 P.M. Guests were received in the library of the Academy, and receiving were Dr. and Mrs. Joe Massee, Dr. and Mrs. John W. Turner and Dr. and Mrs. Clifton.

Dr. Clifton is a former president of the Fulton County Medical Society, and Mrs. Clifton is the former Miss Faye Hollis, assistant secretary of the Fulton County Medical Society for several years.

MAXILLO-FACIAL INJURIES

A survey of the North African and Sicilian campaigns showed that of the total admissions to hospitals 0.5 per cent were for maxillo-facial injuries. Of these, 42 per cent were battle casualties.

The incidence of maxillo-facial injuries compared to total battle casualties was about 22 per cent. In the cases reported, there were no deaths caused primarily by battle-incurred maxillo-facial injury.

GLIDERS CARRY WOUNDED TO HOSPITALS

A glider service was inaugurated in the European Theater to evacuate our wounded from Remagen. Observers reported that the shock incident to being "snatched" into the air was absorbed by an improved towing device. It is now possible that gliders may almost eliminate ambulances for hauling our battle casualties long distances over shell torn roads—giving them a faster, smoother ride to the hospital.

The gliders serve a dual purpose. Coming in to the battle area they can carry twelve litter patients or nineteen walking wounded.

Ambulance gliders were first used experimentally by the British in Burma and New Guinea.

HARMON GENERAL HOSPITAL IS TROPICAL DISEASE CENTER

Harmon General Hospital at Longview, Texas, has been designated for the treatment of tropical diseases. The only other Army tropical disease center is Moore General Hospital at Swannanoa, N. C.

The medical staff of Harmon General Hospital has for some time been engaged in a study of relapsing malaria which has resulted in a permanent contribution to the knowledge of the disease, according to Lieutenant Colonel Francis R. Dieuaide, M.C., Chief of the Tropical Disease Branch, Medical Consultants Division, Office of The Surgeon General. This study is now being extended to other tropical diseases which are rare in this country, such as filariasis, schistosomiasis and dysentery.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALNUT 8911; residence, JACKSON 7979.

NURSE COUNSELING AND PLACEMENT PROGRAM

JULIA M. MILLER, R.N., President,
Georgia League of Nursing Education.
Emory University

For some years nurse organizations have been aware of the need of a counseling and placement service for members of the profession. Wartime conditions with displacement and reassimilation processes have emphasized the great need for the development of a broad program.

A well planned program in this field covers more than a plan to aid the nurse veteran in adjusting to civilian life.

National and state nurse organizations have outlined an overall program which it is hoped will be put into effect in each state. The scope, aims and purposes of this program are as follows:

To develop professional, educational and personal counseling:

- For registered nurses, both military and civilian, both citizens and non-citizens.
- For those civilians and veterans (such as corpsmen, WACS, WAVES, MARINE RESERVES and SPARS) who desire to prepare for auxiliary nursing services such as "practical nursing," etc.
- For veterans and civilians who choose nursing as a professional objective.
- For auxiliary workers who are listed with nurses' professional registries.

Objective: To develop vocational, educational and personal counseling and placement services for all registered nurses and auxiliary workers listed with nurses' professional registries in the United States for service.

Purposes: To foster desirable nursing service for the good of all members of society from a qualitative as well as a quantitative point of view.

- Developing leaders in the nursing profession.

- Developing every professional nurse and auxiliary worker engaged in the care of the sick to serve at the level of her greatest capacity.
- Developing a satisfied nursing personnel.
- Providing more equitable distribution of nursing service and assisting with the establishment of desirable fee schedules and personnel practices.
- Providing assistance re public information.
- Establishing public relations.
- Encouraging the spirit of democracy and free interchange of thought and opinion between employer and prospective employee.

The state counsellor, who also may be assistant executive secretary, travels throughout the State helping to develop local registries to do their part in the program of counseling and placement as a whole.

The local offices will register on a national referral form, all vacancies in the community to be filled by a nurse. The form calls for detailed and complete information about the position to be filled.

The nurse also makes her application on a nationally adopted form which calls for complete information on her record as a whole with references.

This program is not designed for nurse placement only, though seldom can successful placement be done without counseling both to the employer and prospective employee. Nurses may fill in the national application forms when they graduate from a school of nursing and keep it to date annually. This will save a great deal of time in schools of nursing where transcripts and references are made out each time an alumna or past employee wishes to make a change of position. Briefly, the entire record of the graduate nurse, including student record, standardized test scores, etc., may be kept in the counsellor's file.

If the graduate nurse is planning ahead and

(Continued on page 124)

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

SERUM GLOBULIN FOR MEASLES IMMUNIZATION

Sometime ago it was announced in the press that the American Red Cross is preparing concentrated normal human serum gamma globulin from the pooled plasma collected at the many blood donor centers. It was also announced that this globulin is available through the Georgia State Health Department for use in the prevention of measles.

Since that time there have been many requests for this globulin in amounts to indicate that it is wanted for mass immunizations, even to the same extent as smallpox and typhoid vaccine, and diphtheria toxoid. The use of this agent in such a manner at this time is not possible, and perhaps is not advisable.

Stokes, Maris, and Gellis, in the July, 1944, issue of *The Journal of Clinical Investigation*, report a study of 391 susceptible persons who received injections of human immune serum globulin, and that it has striking value in protecting against measles and in reducing the severity of the attack, depending upon when it is given with regard to the time of exposure and upon the dosage of the globulin. Ordman, Jennings, and Janeway, reporting in the same issue of *The Journal of Clinical Investigation*, on a study of a much smaller group, record practically the same findings.

Because the supply of the globulin is limited, and because the passive immunity produced is of short duration (about three weeks), it should be used only on selected cases. As measles is more severe and more often fatal in the very young, it probably should be used for all children under two years of age, and for older children who are acutely or chronically ill. For best results, the globulin should be administered within two to five days after exposure. There may be some attenuation of the disease if given later. Stokes, Maris, and Gellis report that 24 of 31 cases in which the globulin was given after the appearance of Koplik's spots showed some modification of the disease.

Although the investigations quoted above report no untoward reactions, it should be borne in mind that these may occur.

Dr. C. A. Janeway, of the Department of Pediatrics of Harvard Medical School, has prepared the following data on this agent and instructions for its use:

What is this material? This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross.

What is its potency? Preparations of gamma globulin antibodies are standardized so that the concentration of antibody is 25 times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer of measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles before release for general use.

Stability. This material should be kept in the ice box like other biologicals. The dating period at present is set at one year. It is probable that it will retain its potency for longer periods of time.

Indications. At present this material is released *only* for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment of prophylaxis of other childhood diseases is not recommended at present.

Administration and dosage. This material may be administered when indicated to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or to modify the disease is at the discretion of the physician.

For prevention—A dose of 0.03-0.1 cc./lb. body weight should be given as soon after exposure as possible, but will be fairly effective in the first seven days.

For modification—A dose of 0.02-0.025 cc./lb. body weight should be given on or about the fifth day after first definite exposure.

Method of administration—The globulin is injected *intramuscularly*, preferably in the buttocks. For this, a 20 or 21 gauge needle is most satisfactory. Pull back on plunger of syringe before injection to be sure needle is not in vein, *since globulin as now prepared must not be used intravenously*.

Caution—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make injection, otherwise syringe may become frozen.

Jaundice—Blood, plasma, and serum have been found on occasion to contain a jaundice-producing agent. Therefore, it is possible that fractions derived from plasma may contain a similar agent. Such jaundice appears 2-6 months after injection. No jaundice has been attributed to this material so far, but careful records of its use should be kept so that any cases of jaundice occurring 2-6 months after injection may be traced to the particular lot concerned.

Safety—A great many *intramuscular* injections have been given without any serious reactions and with very little local pain in the dosage recommended. Rarely, fever, irritability, or tenderness of the site may follow injection in the first 24 hours.

Duration of effect—A single dose will probably pro-

fect a child for about 3 weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

Results of injection—With any biological system, in which the virulence of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced, the catarrhal symptoms slight, and rash may be evanescent and sparse.

GUY C. LUNSFORD, M.D.

NURSE COUNSELING AND PLACEMENT PROGRAM

(Continued from page 122)

wishes experience at various levels in nursing to prepare herself in a certain field this, too, will be indicated. The counsellor can then notify the nurse when positions are available at each level.

Many nurses in Georgia have expressed a genuine interest in establishing a counseling and placement service in this State.

Auxiliary workers (frequently called vocational or practical nurses or nurse aids) also have access to the counseling and placement service and it is hoped that other health workers (technicians, dental hygienists, etc.) may be included.

Community funds should be made available to support this service, which functions for the health of the community in normal times and in times of disaster.

EXPENDABLE REFRIGERATORS PROLONG LIFE OF WHOLE BLOOD

Whole blood, flown from this country to the European Theater of Operations, keeps in condition for transfusions 5 days longer than formerly, or as long as 21 days, because of a new system of refrigeration inaugurated this month, according to the Office of The Surgeon General.

The bottled blood is now being flown overseas daily in compact, expendable ice-boxes made of metal foil on cotton insulating board which keep the blood within safe temperatures: between 39 and 50 degrees Fahrenheit. The containers, measuring 21 x 21 x 25 inches, weigh only 105 pounds when carrying their full capacity of 24 bottles. Each bottle contains about a pint and a half of whole "O"-type blood.

An elaborate system has been set up overseas to complete delivery. The blood is flown to focal points in all forward areas. Blood bank detachments at these points service all Communications Zone medical installations in the area and truck the blood farther forward to advance detachments which deliver it to the operating surgeons.

NEWS ITEMS

The Fulton County Medical Society met at the Academy of Medicine, Atlanta, May 3. Scientific program: "Peptic Ulcer in Navy Personnel," by Captain Waltman Walters, M. C., U. S. Navy, formerly of the Mayo Clinic staff.

The Ware County Medical Society met at the Hotel Ware May 3. Dr. George E. Atwood, Dr. J. D. Stillwell and Dr. M. M. Harris entertained the members at a dinner preceding the scientific program.

The Eighth District Medical Society met recently at the Y. M. C. A., Waycross. Dr. J. R. Gay presided. Invocation by Rev. G. N. Rainey, pastor of the Trinity Methodist Church; address of welcome by Dr. W. P. Stoner, president of the Ware County Medical Society; the response by Dr. J. A. Leaphart, Jesup. The scientific program: "Neurological Therapy," Dr. Wilford A. Risteen, Augusta; "Fever Therapy and Penicillin," Dr. William A. Clough, Savannah; "Changing Attitudes in Chest Surgery," Dr. Robert C. Major, Augusta; "Medical Affairs in Georgia," Dr. Cleveland Thompson, Milledgeville, president of the Medical Association of Georgia.

The Bibb County Medical Society dinner meeting was held at the New Yorker Cafe, Macon, May 8. Scientific program: "Observations While on Foreign Duty," Colonel Ammons, Cochran Field.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, May 8. Paper: "Treatment of Pre-menstrual Tension and Menorrhagia," Dr. A. J. Kelly.

The Baldwin County Medical Society, Milledgeville, met May 9 with the following members present: Drs. H. D. Allen, J. M. Anderson, S. A. Anderson, R. W. Bradford, R. C. Clodfelter, Y. H. Yarbrough, and C. P. Waller. Paper: "What a Good Mental Hospital Should Be," Dr. Samuel W. Hamilton, mental hospital adviser for the U. S. Public Health Service.

Dr. John D. Wiley, who served as a member of the physician's staff at the Georgia State Hospital, and who for the past year has been at Scott's Hospital, in Milledgeville, has resigned and is now living in Sparta.

Dr. H. A. Dorsey has accepted a state job with the Prison Commission and has moved to Reidsville Prison Farm, where he will be the physician of the prison camp. Dr. Dorsey's home was in Pitts.

The Georgia Baptist Hospital, Atlanta, staff dinner meeting was held May 15 in the Nurses Home dining room. Dr. Chas. E. Rushin, chairman of the Clinico-Pathological Committee, was in charge of the program.

Colonel V. P. Sydenstricker, professor of medicine at the University of Georgia School of Medicine, Augusta, now chief of the United Nations Relief and Rehabilitation Association's Nutrition Service, is one of two American physicians aiding the remaining patients at Belsen Concentration Camp in Germany.

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, Augusta, and Dr. Robert C. Major, of the department of thoracic surgery at the school, recently held a conference with Dr. Rufus Payne, superintendent of the State Tuberculosis Sanatorium at Alto. The teaching at the medical school was considered, particularly regarding tuberculosis.

Dr. E. A. Rosen, Dalton, chief of laboratory at the Station Hospital at the Indiantown Gap Military Reservation, Indiantown Gap, Pa., has been promoted to captain. Captain Rosen entered the service on Dec. 4, 1942. He took a laboratory course for medical officers at Johns Hopkins University. Previous to his arrival at Indiantown Gap, he was stationed at the Lawson General Hospital, Atlanta, Ga., Camp Van Dorn, Miss., and Camp Reynolds, Pa.

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, Augusta, has recommended a \$680,000 expansion program for the school. Dr. Kelly told members of the legislative committee investigating state institutions that the school should be the site of a large general state hospital to provide adequate clinical facilities for medical students. He recommended construction of a hospital with at least 200 beds at a cost of \$400,000. He also recommended a new administrative building costing \$200,000.

The Bibb County Medical Society held its regular meeting in the dining room, Macon Hospital, Macon, May 22.

The Georgia Medical Society held its regular meeting at 612 Drayton Street, Savannah, May 22. Paper: "Differential Diagnosis of Functional Dyspepsia and Peptic Ulcer," Captain M. H. Friedman, Hunter Field.

The Fulton County Medical Society met at the Academy of Medicine, Atlanta, June 7. Scientific program: "Palindromic Rheumatism—Report of Two Cases," Dr. Eustace A. Allen; "Post-War Medical Education," Dean Russell H. Oppenheimer, Emory University School of Medicine; "The Importance of the Narrative Personal History in Physical Diagnosis," Dr. R. S. Leadingham.

Dr. Truman Whitfield, a native of Jasper, will be associated with Dr. J. R. Whitley, 123 King Street, Dalton. For the past two years Dr. Whitfield has been a member of the staff of Erlanger Hospital, Chattanooga, specializing in surgery. Previously he had practiced medicine at Tate.

The Richmond County Medical Society, Augusta, met recently. Dr. Goodrich C. Schaffler, Portland, Ore., was guest speaker. His subject was "The Gynecologic Aspects of Youth and Adolescence." Dr. Schaffler is on the faculty of the University of Oregon Medical School and is also the executive officer of the *Western Journal of Surgery, Obstetrics and Gynecology*.

Dr. Eugene Stead, Jr., Atlanta and Decatur, was appointed acting dean of Emory University School of Medicine, effective June 1.

Dr. R. Morris Paty, Emory University, was appointed acting chairman of the Department of Surgery of Emory University School of Medicine, effective June 1.

Dr. Russell H. Oppenheimer, Atlanta and Emory University, former dean of Emory University School of Medicine, was given a dinner at the Atlanta Biltmore Hotel, June 11, by his friends and was presented two traveling bags.

OBITUARY

Dr. O. C. Gibson, aged 83, a practicing physician at Macon for more than 60 years, died April 23, 1945, at Tampa, Fla., where he lived with his daughter, Mrs. Harry Hudson, since he retired four years ago. Dr. Gibson graduated from the Louisville Medical College, Louisville, Ky., in 1884. Besides his wide medical practice, which included the office of county physician for more than 40 years, Dr. Gibson was for decades a leader in the civic, political and cultural life of Macon. Survivors include his wife, the former Miss Lucinda Balcom; three daughters, Mrs. Harry Hudson, Tampa, Fla.; Mrs. Nan Tarver, Athens; and Mrs. Lucy Lane, Haines City, Fla.; four nephews John Gibson, Macon; W. C. Gibson, Bastrop, La.; Alvin Gibson, Augusta, and Eugene Gibson, Ohio; and one niece, Mrs. K. M. Dickson, Albany. Funeral services were held at Tampa.

Dr. James R. Kinney, aged 82, one of Fort Valley's most prominent physicians, died at his home May 9, 1945. He was born in Wilkinson County, and graduated from the Southern Medical College, Atlanta, in 1889, and from the University of Georgia School of Medicine, Augusta, in 1890. Dr. Kinney served Fort Valley as mayor at one time, and until his illness took an active part in the activities of the town and of the church. Surviving are his wife, the former Miss Estelle James, Fort Valley; one son, Joseph W. Kinney, Tifton; one daughter, Mrs. W. E. Searcy, III, Griffin; two grandchildren, Bill and Jim Searcy; and one brother, W. O. Kinney, Macon. Funeral services were held at the Fort Valley Baptist Church, of which he was a member, with the Rev. Raymond L. Harvey, pastor, and Dr. Aquila Chamlee officiating. Interment was in Oaklawn Cemetery.

Dr. John Horton Mathews, aged 59, prominent physician of Rebecca, died unexpectedly at his home, March 27, 1945. Dr. Mathews graduated from the Birmingham Medical College, Birmingham, Ala., in 1915, and from the Graefenberg Medical Institute, Dadeville, Ala., in 1918.

Lieutenant Commander Daniel Joseph McCarthy, U. S. N. R., Savannah, was killed in action in the Pacific Theatre. Word of his death was received by his parents, Mr. and Mrs. Cornelius A. McCarthy, and his wife, Mrs. Lillian Helmly McCarthy, from the Navy Department via telegram April 12, 1945. A Savannahian, Lieut. Comdr. McCarthy received his early education there, graduating from the Benedictine Military School in 1926, where he served as senior captain of the cadet

corps. He then attended Springhill College in Mobile, where in 1930 he was graduated magna cum laude, with a bachelor of arts degree. He graduated from the St. Louis University School of Medicine, St. Louis, Mo., in 1935, and had the honor of being selected as an intern in the St. Louis City Hospital. From there he returned to Savannah, serving part of 1936 and 1937 as assistant resident surgeon at St. Joseph's Hospital. In 1937 he entered the private practice of medicine and surgery. In 1941 he was called as a reserve officer for duty with the Navy and served in the Atlantic, Mediterranean and Pacific battle areas. His survivors include, in addition to his parents, his wife, who resides with her parents, Mr. and Mrs. Hugh H. Helmlly, at 820 East Thirty-ninth Street, Savannah; two daughters, Elizabeth Linden, aged 18 months, and Mary Anne, aged 3 months. He was a member of the Georgia Medical Society, the Medical Association of Georgia, and the Cathedral of St. John the Baptist.

Dr. Otto W. Schwalb, aged 43, native Savannahian and city physician from 1931 to 1937, died at Fort Lauderdale, Fla., April 17, 1945, where he had been serving as county health physician. He graduated from Savannah High School in 1921, and from the University of Georgia School of Medicine, Augusta, in 1928. Dr. Schwalb served a two-year internship in the Savannah and St. Joseph's hospitals before beginning the general practice of his profession. He was a member of the Georgia Medical Society and the Medical Association of Georgia. He is survived by his wife, Mrs. Agnes Sullivan Schwab; a son, Otto Schwalb, Jr.; a daughter, Suzanne Schwalb; his mother, Mrs. John Schwalb, Savannah; a sister, Miss Gertrude Schwalb, Savannah; and two brothers, Captain Clifford T. Schwalb, now in the Hawaiian Islands, and Major John Frederick Schwalb, retired, of Isle of Hope. Funeral services and interment at Savannah.

Dr. W. D. Spearman, aged 69, prominent physician of Social Circle, died April 30, 1945. Dr. Spearman was the son of the late Col. and Mrs. Toombs Spearman, Social Circle. He was graduated from the University of Georgia School of Medicine, Augusta, in 1900. He is survived by his wife, the former Miss Edna Gunter; one daughter, Mrs. Bearden Chambers, Madison; one son, Lieut. Col. Walter D. Spearman, with the 115th General Hospital, England; two sisters, Mrs. Emma Gresham, Hamilton; Mrs. W. H. Hurst, Macon; three brothers, Whit B. Spearman, Social Circle; R. E. Spearman, Macon; and J. F. Spearman, Anniston, Ala. Funeral services were held at the residence, with Rev. G. B. Henderson, pastor of the Methodist Church, officiating, and interment followed at Circle View Cemetery.

Dr. Christine Walkonig, aged 67, Atlanta, died at his residence, April 13, 1945. He was born in Baltimore, Md., and graduated from the College of Physicians and Surgeons of Baltimore in 1902. In 1912 he graduated from the University of Maryland School of Medicine and College of Surgeons, Baltimore. He practiced medicine

in Baltimore, Atlanta, Sarasota, Fla., and Tampa. Dr. Walkonig is survived by his wife, the former Miss Florence A. Mills, of Atlanta; four nephews and three nieces. Funeral services were held at the Awtry & Lowndes Chapel, the Rev. Hoke Sewell officiating. Burial in West View Abbey.

THE PHYSICIAN'S BOOKSHELF

Plaster of Paris Technic, Dr. Geckeler's handbook on plaster of paris technic is really a long needed adjunct to present day and the future practice of general medicine and surgery. Its main feature is the way the principles of the use of plaster of paris are brought out effectively and to the point by its superb step-by-step illustrations. As for the written material, its practicability is retained by being concise and the omission of unnecessary details.

Dr. Geckeler has intentionally omitted orthopedic technic and the reduction of fractures in his treatise so that its scope may be in view at all times. The handbook, nevertheless, covers in a simple method the practical use of plaster of paris in all possible fractures sustained by the human skeletal structures, with chapters on "errors and difficulties" and "follow-up care."

To complete the war edition the author has added a few brief special topics of interest on "plaster as used in trauma and inflammation of soft tissue, burns and war surgery."

In conclusion, may I say that this handbook on plaster of paris has not only proved its worth in my role as a general surgeon, but is especially invaluable in my industrial traumas where plaster of paris was indicated as a mortality.

R. L. ROGERS, M.D.

ENRICHMENT OF BREAD AFTER THE WAR

Pointing out that both federal and state action will be required to assure continuation of the benefits of enriched bread, now compulsory under wartime regulations, *The Journal of the American Medical Association* for January 20 declares such a program should have the active support of all informed persons. *The Journal* explains that "Among the important applications of the numerous advances in nutrition is the development of the program for enrichment of food. By order of the War Food Administration all haker's white bread, white rolls and sweet rolls must be enriched with vitamins of the B complex and iron to stated levels. The content of enriched baked goods in thiamine, niacin and iron is thus brought to the desirable high levels of these constituents found in similar products made from whole wheat flour. . . ."

"The continuance of these benefits to the nation's nutritional standard is not now assured beyond the duration of the emergency. The compulsory enrichment of baker's white bread and rolls terminates with the resolution of the wartime powers of the War Food Administration. The problem then reverts on the individual states as to whether enrichment of these foods will continue to be required. Legislation at the federal level would affect only those products handled in interstate commerce. . . ."

EPILEPSY

Eighty out of every hundred persons with epilepsy can lead normal lives and are employable. This is one of the main conclusions of *Epilepsy—The Ghost is Out of the Closet*, a 32-page pamphlet by Herbert Yahraes published today by the Public Affairs Committee, Inc., of New York.

The importance of this information becomes apparent when one realizes that as many people suffer from epilepsy as from active tuberculosis or diabetes; that the war will increase the incidence of the disease because of the increased number of head injuries and because of lowered resistance brought about by emotional shock or excessive fatigue.

If "jobs for all after the war" is to include jobs for epileptic veterans and other sufferers of this fairly common disease, the information in this Public Affairs Pamphlet should be widely disseminated in order to overcome the fear, ignorance, and superstition that surround the word "epilepsy."

"Epileptics," according to the pamphlet, "have a right to be hired on the basis of what they can do"—in the same manner as any other person.

They have already been employed successfully as doctors, lawyers, ministers, engineers, teachers, salesmen, farmers, clerks, laborers, mechanics, stenographers, dress-makers, reporters, interior decorators, factory workers, beauticians, actresses, dancers, writers, plumbers, and musicians.

Epileptics are not intellectually inferior, Mr. Yahraes writes, and work is an important form of treatment for most patients. "Their fellow workers will find that, except for brief periods of illness, most epileptics are as likable and competent and courageous as anybody else."

The booklet describes the disease, tells what causes it, how it is recognized, and how it can be treated medically, but the most significant sections are the ones on how the epileptic should be treated by society: Should an epileptic child go to school? Should an epileptic be sent away from his family? May he marry? have children? hold a job?

Mr. Yahraes concludes with this advice for all:

We should acquaint ourselves with the new knowledge about epilepsy.

We should use our new information to persuade uninformed persons that epilepsy is not a shameful disease—that with the passage of time and with the right treatment, a patient tends to grow better instead of worse—that the disorder *can* be controlled.

In short, we can spread the truth that epileptics are people and ask only to be treated as such.

Epilepsy—The Ghost is Out of the Closet, by Her-

bert Yahraes, is the ninety-eighth in the series of popular, factual, ten-cent pamphlets published by the Public Affairs Committee, Inc., a nonprofit, educational organization at 30 Rockefeller Plaza, New York 20, N. Y.

"THE DIAGNOSIS OF HYDRONEPHROSIS CAUSED BY ACCESSORY RENAL VESSELS"

EARL C. LOWRY, *Col., M.C.*, JOSEPH C. HAYWARD, *Major, M.C.*, and DONALD E. BEARD, *Major, M.C.*

The Journal of Urology, Vol. 52, No. 6,

December, 1944

ABSTRACT

The authors describe three separate and distinct types of pyelograms encountered in hydronephrosis caused by aberrant or accessory renal vessels. The type of pyelogram observed depends upon the site of the obstruction; that is, whether the accessory vessels cross the renal pelvis, the uretero-pelvic junction, or the ureter. The pyelogram seen when the obstruction is at the uretero-pelvic junction is typical and familiar to all, but when the obstruction is proximal to the uretero-pelvic junction, a characteristic crescent-shaped deformity is observed in the pyelogram which has previously been unrecognized and little publicized. The differential diagnosis of hydronephrosis was discussed and a case reported of a giant hydronephrosis containing 5100 cc. of sero-purulent fluid in which the above mentioned characteristic crescent-shaped deformity led to an accurate preoperative diagnosis.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

GOULD'S MEDICAL DICTIONARY

*Latest Edition, 1945 Printing,
Thumb Indexed*

Price \$7.50

THE BLAKISTON COMPANY

1012 Walnut Street

Philadelphia 5, Pennsylvania



LEG MAKE-UP FOR THE ALLERGIC PATIENT

- 3 SHADES
- PEACHGLOW (LIGHT)
 - RIO (MEDIUM)
 - SUNGLOW (DARK)

AR-EX COSMETIC HOSE contains no rosin, aniline dyes, or other known skin irritants. Goes on smoothly, does not rub off, but is easily removed with soap and water. Send for Free Formulary.



FREE FORMULARY

DR. _____
ADDRESS _____
CITY _____
STATE _____

AR-EX COSMETICS, INC.

1036 W. VAN BUREN ST. CHICAGO 7, ILL.

Advertisement



From where I sit by Joe Marsh

How Sober Hoskins got his name

Everybody kids Sober Hoskins about his name. Of course, they allow that it's appropriate. Sober never drinks anything stronger than a glass of beer. And a harder worker in the fields there never was.

According to Dr. Walters, who brought Sober into the world, "Sober's dad named him 'Sober' because he looked that way when he was born. Like he called his daughters 'Gay' and 'Prissy.' And it's had its effect on all of them," the doctor adds with a chuckle. (Prissy is the old maid in the Hoskins' family.)

From where I sit, Sober's dad had the right idea. Naming children after virtues is a fine old American custom. Look at the names of our pioneers and pilgrims: Faith, Pious, Charity, Hope, Ernest.

Maybe we should use such names more often. And one I'd like to add is "Tolerance." If we all had Tolerance for a middle name, and lived up to it, we'd have a better, happier world.

Joe Marsh

COOK COUNTY Graduate School of Medicine

(In Affiliation with Cook County Hospital)

Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting June 18, July 2, and every two weeks during the year. One Week Course Surgery of Colon and Rectum June 11 and September 10.

GYNECOLOGY—Two Weeks Intensive Course June 18. One Week Personal Course Vaginal Approach to Pelvic Surgery July 9.

OBSTETRICS—Two Weeks Intensive Course June 4 and October 8.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

ELECTROCARDIOGRAPHY & HEART DISEASE—Two Weeks Intensive Course starting August 6.

General, Intensive and Special Courses in All Branches of Medicine, Surgery and the Specialties.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street,
Chicago 12, Illinois

A. J. Ayers, M.D.

X-Ray and Clinical Laboratories

Serological, Wassermann and Kahn Tests, Bacteriological Examinations, Autogenous Vaccines, Blood Chemistry, Basal Metabolism, Tissue Examination, gross and microscopic, Autopsy and Toxicological Examinations and Friedman's Test for Pregnancy. Well equipped X-Ray Laboratory, diagnostic and therapeutic. Containers and information furnished upon request. Reports telegraphed when desired.

111 MEDICAL ARTS BUILDING
PHONE JA. 3937
ATLANTA, GA.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, July, 1945

Number 7

THE EVOLUTION OF MEDICINE

CLEVELAND THOMPSON, M.D.

Millen

Mr. Chancellor, Mr. Dean, Members of the Faculty, Officers of the Armed Forces, Members of the Graduating Class, their Families, Friends, and Guests:

On this occasion thirty-five years ago, when I had the good fortune to be awarded the diploma of this medical school, I little thought I would ever be called back and given the privilege and honor of making a commencement address at my Alma Mater. I accepted the invitation with some misgiving, but the honor I could not decline.

In order to find out where we are medically and to catalog some of the things we must have if we are to progress further, I want to sketchily trace for you this evening the slow, faltering development of medical care from its earliest beginnings to the successes that have come to scientists in recent years. I think it well to recall to you your professional heritage; it is well for me to pause in the busy routine of a doctor's day and reverently recount the cost in solitude, arduous toil and hardship that it took to produce the scientific knowledge and equipment with which I am privileged to go about even the most commonplace details of my practice today. I want to name them over not only to stir in our hearts "gratitude for our benefits" which Seneca says "repays the first installment of our debt," but to offer to you doctors the challenge of high ideals for research, and generosity in sharing the reward of your study. After all, says Osler, "The practice

of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

If you had been a privileged young man living in the early ages of civilization and culture, say in Egypt, about 1300 years B. C., you would have been taught the basic principles of arithmetic and geometry; of architecture and sculpture; of music with harp playing, of military science; of commercial law, of shipbuilding and transportation, and of commerce and trade. But if you had wished to dedicate yourself to the "healing art," you would have been taught that supernatural forces were the causes of disease, and you would have had to learn different ceremonies for overcoming these forces of evil. As a "medicine man" you would have been versed in the different kinds of spirits, almost infinite in number, that produce disease in your patients, and the many methods of mystery and magic used to drive them out of the sick body. You would have been expected not only to heal your patient, but to cast the sickness upon his enemy, practicing thus the white magic of healing as well as the black magic of destruction. If your patient came with a splitting headache, and none of your mysterious ceremonies and invocations to the gods gave relief, nor were you able to discern which of the gods was responsible for this poor fellow's condition, you would be compelled to open his skull and release the spirits torturing him. After having him securely tied down, with his head upon a stone, you would come with your scalpel — a sharp flint, and your sponges — a bundle of straw. After lacerating the scalp and mopping blood, you would proceed to grind a hole into the skull. If this operation did not give relief, holy smoke! You have not

opened the side of the skull inhabited by the spirits; you must operate again on another area! There is archeologic proof that some skulls were thus perforated as many as five times for the release of evil spirits that caused the headache. The medicaments you had to apply were the outcome of superstition and spirit worship. You would treat tuberculosis with the lungs of a longwinded animal, the fox; baldness with the fat of a hairy animal, a bear. For nervousness and timidity you would dose your patient with potions from the heart of a brave man, a soldier.

So this was the medicine practiced on the Nile, as well as in Assyria, Babylon, Persia and Phoenicia when Greece with her unparalleled culture and grandeur took her place in the sun.

Had you been a student in Greece 500 years B. C., you would have grown up under the tutelage of the great Socrates, of Aristotle, or Plato. You would have learned history from Herodotus, you would have frequented the dramas of Sophocles and Euripides, and you would have thrilled to the great writings of Pythagoras. In fact you could have been given no more radiantly cultured era in which to live. It was among these great spirits that the father of medicine, Hippocrates, spent his life. He looked upon disease not with superstition but with a sane, wise judgment; he separated medicine from religion. "Disease," he said, "is a part of the order of nature, and to conquer it, one must study it as one does any other natural event." You would have been trained by a thoughtful, philosophical, methodical teacher had you followed in the train of Hippocrates. He would have taught you the quality of the pulse, the meaning of certain types of respiration; he would have stressed nourishment and diets, and the differences in the long thin and the short thick individual. He would have taught you to keep accurate records of the cases he treated, recording honestly his mistaken diagnoses as readily as his successes.

Hippocrates use of the mind and senses, together with his complete honesty and his high conception of the dignity of his profession, as well as his deep respect for his pa-

tients, made him worthy of the veneration with which he has been held by all physicians during the centuries since he lived.

But within a few centuries through conquest, "the grandeur that was Greece became the glory that was Rome." Alas! the glory of Rome did not include medical science which deteriorated under Roman supremacy. It was again confused with superstitious and religious ceremonies. Rapidly it lost the impetus given it by Hippocrates. Only once did the Romans raise medicine to anything near the dignity that Hippocrates had given it. It was Galen who for centuries was destined to influence medicine more than any other man. This man Galen was an objective personality, a typical extrovert, an egotistical showman. He had great intelligence but he lacked the honesty and breadth of vision that Hippocrates had possessed. He was an indefatigable worker and wrote over 500 treatises rehashing the then known medical knowledge of the world. At the same time he carried on a tremendous practice and taught scores of medical students. For fifteen centuries after Galen there was little original work done in the medical field. After the fall of Rome, medicine was again essentially in the hands of the priests — and doomed to turn back to superstition and quackery.

We pass hastily over the middle ages and the Renaissance, though the 16th century did give to the world three distinguished men in as many fields of medicine. They stood almost alone, not representative of the decadent state of the profession at that time. Paracelsus was a pioneer in chemistry, Vesalius in anatomy, and Pare in surgery, and many of their practices are in use today.

The gods were lavish with genius during the 16th and 17th centuries. There were men and events that made the period rival the "golden era" of Greece. Queen Elizabeth was sovereign of Britain, Shakespeare, Ben Johnson, Fletcher, Beaumont, Marlow, Spencer, Francis Bacon, Milton and Pepys were brilliant contemporaries. The first American colonies were growing, Harvard University had been established, and all in all the occident had given birth

to a modern world. But I think I speak conservatively when I say that not one of these great men contributed as much to mankind as the young English doctor who had graduated from Padua and located in London during the time the Shakespearean drama was creating such a furor there. Young William Harvey, born in 1578, had wandered down to Italy where he heard discussions early in his career at Padua concerning the anatomy of the heart and blood vessels, no one had a clear conception of them. The man Servetus had done much research and promised the answer fifty years before but he had offended Calvin, the fundamentalist, with an expression of liberal religious tenets, and had been condemned as a heretic and burned at the stake. Harvey's experiments and records are fascinating indeed, and his real discovery was that "blood moved in a circle" and he demonstrated exactly the path which it followed. When we consider how fundamental this knowledge is, we readily understand how it completely revolutionized the science of medicine. In Harvey's book on "Anatomical Experiments on the Nature of the Heart and Blood in Animals," he not only announced the discovery but gave a clear statement of the invaluable conclusions to which it led. Though this book was published in the era between Shakespeare's greatest dramas and Milton's *Paradise Lost*, some sober scholars have considered it the greatest book ever written.

Since the 17th century the progress of medicine has never taken a holiday. To try to name the great turning points would be but to recount a full book. There was great concern and investigation in many sources over childbirth fatalities. "Dr. Oliver Wendell Holmes at Harvard Medical School was angered by the mysterious death of young mothers in childbirth, and he searched through uncharted regions of a medical tradition that knew no Lister, no Pasteur, no germ theory and no antisepsis until he discovered the contagiousness of puerperal fever." He wrote in an essay in 1843, "There is no tone deep enough for regret, and no voice loud enough for warning. I am too much in earnest for either humility or vanity, but I do entreat those

who hold the keys of life and death to listen to me for this once. I ask no personal favor, but I beg to be heard in behalf of those women whose lives are at stake until some stronger voice shall plead for them."

At this very time two men were using the keys of life in their laboratories to unlock the mysteries of infection, the surgeon, Joseph Lister in Scotland, and the chemist, Louis Pasteur in France. "Their findings opened up a new heaven in medicine and a new earth in surgery." To contemplate the utter helplessness we would feel today in the presence of germs without the knowledge of asepsis should make us humble indeed. Lister fought the battle for us in the operating rooms of Glasgow, and startled the scientific world.

Clendening says: "The air of surgery from 1867 to 1885 was full of carbolic acid and controversy." Some surgeons laughed, most of them winked; some got angry. But some believed in Lister and went to Glasgow to see his results. "Truth when first presented is always denied, but later there comes a state when the man says: 'I always thought so.'" It is hard for us to conceive today of a complete ignorance of germs — the unseen, unsuspected enemies of our grandfathers! For example, in the surgery of the 19th century of the thousands of hip amputations done in Napoleon's army, only three survived.

Lister, puzzled and searching, got his first hint of germs from a strange paper written by a chemist named Louis Pasteur, in which he discussed the difference in fermentation and putrefaction. "It is hard," Dr. Osler says in speaking of Pasteur, "to decide whether to admire more the man or his method, the life or his work." His name is a household word throughout the civilized world today. His multitudinous researches led to many discoveries, three of which are of supreme importance: 1. A knowledge of the true nature of the processes of fermentation; 2. A knowledge of the cause of the chief maladies which have scourged man and animals; 3. A knowledge of the measures by which either the body may be protected against these diseases, or the poison neutralized when once it is within the body." He had a long, tedious road

that led through prodigious research and endless experimentation. He met with ridicule, with controversy, with much scorn from the medical profession; but he lived to see his work approved and appreciated. On his seventieth birthday the great theatre of the Sarbonne was filled with eager admirers. While the band played a triumphal march, Pasteur entered leaning on the arm of the President of the Republic. There were congratulatory expressions from the scientific organizations of many countries. The great Lister, who represented the Royal Societies of London and Edinburgh, brought to Pasteur the homage of medicine and surgery. He said: "You have raised the veil which for centuries had covered infectious diseases; you have discovered and demonstrated their microbial nature." Then says the biographer: "When Pasteur rose to embrace Lister, the sight of those two men gave the impression of a brotherhood of science laboring to diminish the suffering and sorrows of humanity."

Lord Lister, while struggling over the great problems of asepsis, felt a gratitude, immeasurable, to those American scientists who had discovered anesthesia. Many minds were engaged upon the problem at the same time, for the horror of surgery without some panacea for pain drove some of the most gifted men away from the profession. Charles Darwin himself said that he could not enter the field of surgery because of the suffering it entailed. We know well the controversy that filled a half century over who first successfully used anesthesia. Dr. W. G. G. Morton, a dentist of Boston, and his partner, Dr. Horace Wells, were clever men. They were ingenious mechanics and ahead of their time in devising ways and means of helping human beings grind their food. They wanted to pull teeth and set up dentures in the mouths of their patients, who were willing to shed the teeth, but panicky over the pain involved. The two men grew hopeful over the possibility of deadening pain for a few minutes while teeth were being pulled, but before either hit upon the agent of mercy they dissolved partnership; Dr. Wells moved to Hartford, Connecticut, and both continued the quest.

Dr. Wells successfully used "laughing gas" in December, 1844, but in an effort to advertise himself as well as his discovery, he put on a public demonstration during which his patient died. This tragedy so humiliated and disappointed him that he committed suicide and got himself out of the acrimonious debate. Dr. Morton successfully used the agent in 1846 and it was immediately given publicity by Dr. Henry J. Bigelow in the *Boston Medical and Surgical Journal*; also by Dr. Oliver Wendell Holmes, who gave it the name anesthetic, and the state of being — anesthesia. The rural section of Georgia — which was all of it at that time — had few press agents, and Yankees have always known that Southerners have no push nor acquisitiveness. But they did read the papers; and when Dr. Crawford W. Long of Jefferson, Georgia, saw a stirring article about the marvelous Dr. Morton who had used anesthesia in 1846, he quietly reported operations he had done since 1842 with laughing gas and ether. Then the controversy began. The War Between the States didn't help to quiet it any. Dr. Morton might have surrendered all honors to Dr. Long had his followers been willing to do so, but be it to the eternal glory of Dr. Long he went quietly about his profession, for many years unrecognized, and persistently refused to enrich himself at the expense of suffering humanity, though he realized the importance of his discovery and his priority. During the last year of the war he put the papers confirming his discovery in a bottle and entrusted them to his daughter who was fleeing to a distant part of the country before the advance of the Federal troops. Clendenen says: "Of all the claimants, only Crawford W. Long emerges from the ether controversy with an unspotted crest."

In 1828, at the request of Dr. Milton Antony and friends of Augusta, Georgia, the charter was granted for the Medical Institute of Georgia. It was so well received that Dr. Antony appeared before the Legislature again in 1833 with a request to enlarge its powers and change its name to the Medical College of Georgia. This same brilliant man established the *Southern Medical Journal* and was for a

long time its editor. A century has passed since then — a century brilliant in achievements in the science of medicine. A discussion of the advance in medical knowledge and technics would fill a very large volume. Malaria, typhoid fever, the venereal diseases, various infections, and tuberculosis are as good as conquered. Then there is the advance in physical medicine, x-ray, radium, etc., and the discovery of the internal secretions and their application in medicine, the vitamins and their application in the nutritional diseases; the discovery of the four blood types by our own Dr. Moss, and the perfection of blood transfusion and the use of blood plasma in shock. The nature and treatment of the anemias, especially by liver therapy; the marvelous advance in psychiatry; the introduction of the wonder drugs, the sulfonamides and penicillin, with their peculiarities and applications in medicine. Wonder drugs they are! The best scientists and laboratories of the allied nations have been engaged in their development and many, many millions of dollars have been spent. To look at a child critically ill with pneumonia, a young man in extremis with cerebrospinal meningitis, and a young mother with septicemia; then in a few hours, after the use of these drugs, to see all of them convalescing and asking for food, is marvelous. The benefits from these advances in medicine to mankind are truly astounding and immeasurable. They are a monument greater than a Pharaoh ever built.

Well, here we are. What shall we do now? The 20th century crusade is on! Let me ask you, are all these advances in medicine worth the time, sacrifice, toil, money — even blood and lives — it took to produce them?

The growth and development in this century of the medical science will take place mostly in laboratories of research, and there are many unsolved mysteries about human disease and infection. We have great pride in the men of this medical school who have contributed in no small way to this century of medical progress. One of my cherished wishes is to see our Alma Mater a complete medical center here in Augusta with laboratory equipment and

clinical facilities second to none in the country, with fellowships and endowments that will induce more gifted and sincere scientists to labor here toward the perfecting of medical knowledge. I should like to see this field of work so secure and untrammelled financially that internships for gifted graduates could be prolonged as indefinitely as necessary for the completion of a quest — no matter how tedious nor how much delayed. Our State has every right to be proud of her investment here. Great doctors have gone out from her halls, but among the things this medical school needs now are:

1. Increased funds for maintenance of an expanded research program.

2. The erection of a new main building west of the Dugas and Murphey buildings to house all departments now in the main academic building. This structure will cost about \$200,000, exclusive of equipment.

3. The renovation of the present main academic building into a dormitory, intern quarters and student union building, with provision for a swimming pool and gymnasium, and the transformation of the present dining room into an up-to-date cafeteria.

4. The addition of full-time clinical departments in all the important specialties.

5. The expansion of the medical state-aid program in order to provide ample medical and surgical care for the hundreds of indigent sick all over the State. This may entail construction of a state hospital, or merely provision by the present hospital of sufficient beds to care for the increased number of patients.

6. Increase in the number of clinical teachers in order to enable the School of Medicine to participate fully in post-graduate medical teaching.

7. Raising of standards in order to turn out graduates with the best possible qualifications.

These are the needed additions to our medical school, but added to this: It is a well recognized fact that the distribution of medical care in our State, as in all the others, is far from perfect. The principal lack of adequate medical care is to be found in the sparsely settled rural coun-

ties, but even in populous areas there are individuals who do not have proper attention in time.

It is the obligation of the State to provide adequate medical and surgical care for all of its citizens who are not able to provide for themselves. This is the best policy from the economic as well as from the altruistic viewpoints. It is not the function of the Federal Government to provide this care through the creation of an enormous bureaucracy. That would throw the practice of medicine into politics and waste the people's money.

A commission is now at work in Georgia preparing to make recommendations for the better distribution of the adequate medical and surgical care of our people. It is too early to predict what these recommendations will be, but we can at least hope that they will include the expansion of the University of Georgia Medical School as the focal point about which such care will develop and from which it will radiate.

And now, young men and women who are becoming alumni tonight, we welcome you into our circles. You are one of us; we need you — a great field of labor awaits you. There are still many mysteries about curing illnesses and prolonging lives. Wherever your career takes you, you hold in your hands today the answer to service and peace. If you devote yourselves to your profession, no discouragements, disappointments, nor morbid dreads will take possession of you. Work on! That is the secret of happiness and success, absorption in your art, growth in your profession.

"The mintage of wisdom is to know that rest is rust, and that real life is in love, laughter and work."

Above all, keep your integrity! No success, no accomplishment, is worth the price of honesty. Some physicians are selfseeking, vain showmen. That weakness unbalances their honest relationship with other doctors, it marks them unworthy of the heritage we have taken inventory of tonight. "The ethical spirit is the Palladium, the soul of medicine

And when it fails, fight as we will, we die
And while it lasts, we cannot wholly end"—

(Bibliography will be included in author's reprint).

RELIEF FROM PAIN

W. A. RISTEEN, M.D.

Augusta

For proper discussion of a modality of sensation one should present certain basic features of the subject, such as definition, anatomy and physiology of its pathways and their connections with the neuroaxis. As far as I am concerned these preparatory statements will be very brief. I have no definition of pain that describes this modality in a better manner than any other individual. The basic anatomy and physiology of pain are well known to each of you and there is no need to repeat these points at this time.

We are interested in discussing measures for relief of pain. From the start to the finish of this problem we must depend upon the individual's evaluation of his pain and his evaluation of success or failure of treatment.

In attack upon pain we have the several usual routes and methods:

1. Chemotherapy which alters the individual's ability to elaborate and synthesize the stimulus into the consciousness.
2. Removal of stimulus.
3. Isolation of the affected part.

Recently interest has been aroused in certain other forms of attack, and these will be discussed relative to the method outlined above.

The depressive actions of certain drugs are well known. Numerous instances are reported in which the concentration of drug necessary for pain alleviation so changes cerebral function that cooperation of the patient in nursing care, food intake and attempts in therapy is impossible.

The actual dollar outlay for drugs necessary to combat pain may in some instances assume proportions far out of reach of most patients.

Altered physiology due to drugs is seen frequently. These people have little to look forward to. They become further debilitated by pain; or if pain free, from drugs. This state of affairs may frequently be avoided by surgical intervention and relief

of their retractable pain.

Attack by removal of the stimulus is surgical in method. The pain associated with foreign bodies, calculi, localized injections and many other lesions is alleviated with the removal of the offending stimulus.

The large group of painful conditions that does not respond to either of the above general methods must be attacked by interpretation of pain pathways. This group may be subdivided into the following more common conditions:

1. Facial neuralgias.

Whether major or minor, or of the atypical variety, these conditions have been treated by divisions of branches of the 5th nerve. Insofar as no pathologic condition has been demonstrated in these neuralgias we are in reality isolating an area of the body by removing its sensory connections with the neuroaxis. Whether the temporal approach or the suboccipital approach to the nerve is made, the results are by and large equal. Claims made for superiority of either approach do not stand up with study of comparable groups of patients.

It is my personal feeling that this group represents a neurovascular imbalance and the final form of therapy will be directed toward the promoting of a normal vascular harmony. Recently we have tried vasodilating substances with these patients. Nicotinic acid is the drug of choice. The main factors are: to use sufficient drug and to maintain adequate flush over a period of several hours. We have developed a method for doing this and have had pleasing results in 8 cases.

Glossopharyngeal neuralgias fall into this same grouping. Surgical therapy is division of the 9th nerve by suboccipital route. We have used prolonged nicotinic acid therapy in 1 case with good results.

2. Pain originating at levels or in areas supplied by the spinal nerves.

This group covers the remainder of the body insofar as somatic pain is concerned. Surgical management of the pain problem in this group has been brought to its present state mainly through experience with cancer, and it is best to use malignant lesions for our general outline of attack. A malignant lesion is painful because of:

1. Ulceration, and secondary infection.
2. Pressure upon or direct involvement of nerves.
3. Obstruction of a hollow viscus.
4. Invasion of an organ by cancer.
5. Involvement of bone.

These causes are all well and good for a working basis but combinations of these causes makes each patient an individual problem. Successful therapy must take into account the psychogenic, the economic, the physiologic as well as the pathologic factors in the problem. Assuming that proper drug, diet and environmental regimens have been established, and pain persists in the patient with cancer, we have a few avenues of attack open. With adequate knowledge of the anatomic relationship of the peripheral nerves and of the pain pathways within the neuroaxis, one may proceed to isolate the lesion from any further connection with the thalamus and cortex.

Individual nerve sections, except in the head, are of little or no value. The spread of the lesion to adjacent dermatomes makes this procedure just one of many to follow. Pain in areas supplied by the spinal nerves may be cared for by:

Alcohol injections. In our opinion this therapy is suited to the lumbosacral outflow only. Here a wide range of segments may be reached with a single injection into the subarachnoid space.

Section of the spinothalamic tracts by chordotomy. In patients who are reasonable operative risks, have a life expectancy of at least six months under any condition, and whose care has been such as to evaluate and find wanting the usual drug therapy, chordotomy is indicated.

If the pain is truly unilateral, the opposite tract section will suffice. In visceral pain it is usually impossible to lateralize the pain, and bilateral chordotomy is the procedure of choice. At least three levels should be allowed between the two cord incisions.

Posterior rhizotomy. For a localized peripheral lesion of an extremity or for a lesion over a few body segments, rhizotomy is probably a good procedure. These cases are few and chordotomy has largely replaced rhizotomy in the relief of pain due

to carcinoma. It is still good therapy for other types of pain, provided the laminectomy does not continue over a wide distance.

When pain about the head and jaws is due to an expanding lesion, attack is mainly on the 5th and 9th pairs of cerebral nerves. The procedures are, in the main, classified as for the spinal nerves. Alcohol injections of the 2nd and 3rd divisions of the 5th nerve are not as a rule difficult. For first division pain, or in individuals in whom the spread of malignancy may involve the first division, temporal or suboccipital attack in the entire 5th outflow for pain is indicated. The majority of patients will tolerate temporal section of the ganglion far better than tractotomy. No one is able to differentiate discomfort into its components of pain, temperature and pressure. Tractotomy will bring the same after complaints that come from chordotomy without section of the anterior spinothalamic tracts. The patient is still uncomfortable. Pain is gone, but the sensation of burning and pressure will remain. Although pressure may mediate to a large degree through the 7th pair of cerebral nerves, there is some pressure sense in the 5th nerves.

Section of the 9th pair of cerebral nerves must be done by a suboccipital approach. In this procedure the cerebellar damage so often encountered in tractotomies is seldom a factor. It might be well at this point to call attention to a few general do's and don'ts concerning the above procedures. One must remember that the lateral spinothalamic tract is the only area in which both visceral and somatic pain fibers may be sectioned together. Alcohol does not reach both types of fiber for any great distance. Rhizotomy does not bring comfort in visceral diseases without a long and mutilating operative procedure. Combined alcohol therapy and chordotomy make up a rather dangerous therapy. Bladder and bowel disturbances are the rule after this combination rather than the exception.

It seems reasonable to suppose that a lesion does not ever demarcate itself by its pain outline. When one evaluates a patient preparatory to surgery for relief of pain in any lesion, the thought of its future pain pattern must be kept in mind. The final choice of method for isolation of the

lesion will then include pathways several segments above its present boundary. The therapy of trying subarachnoid alcohol as a test procedure is good therapy but in practice is more often than not disastrous. Rather than do this, a chordotomy as the first and only procedure will give better results. Chordotomy as usually done results in severance of the lateral spinothalamic tracts. Any individual suffering from an invading and expanding lesion will have discomfort because of pressure. Unless the anterior spinothalamic tract is sectioned such an individual will not be comfortable. This necessitates a more extensive incision in the cord but is, I believe, justified.

When one studies painful conditions, many interesting and valuable therapeutic suggestions will from time-to-time appear. I would like to outline briefly some of our own findings and observations. Dr. Perry Volpitta and I have been studying various sympathetic blocks and their effects. We started our work with attack upon cerebral vascular occlusions. We noted that a large percentage of the thrombus group complained of headache. With the release of the constrictor elements to the vessels of the head by means of stellate ganglion block, this pain was relieved. We also noted in the older group of thrombus and hemorrhage patients, older in the period of time between onset of the lesion and treatment, that many had serious complaints of pain in the spastic hemiplegic side. We have thought that this pain was due to hypertonicity and to secondary joint restrictions. After block, these people showed relaxation and relief of pain even when no great return of motor function was noted. We next blocked the stellate ganglion of a woman who had had cerebral embolus five months previously. She was paralyzed totally and complained bitterly of severe pain when the spastic side was moved. After block there was relaxation and a nearly complete reduction in the pain. There was no return of motor power. We then blocked the stellate ganglion in patients with typical postencephalitic Parkinson's disease. Both were rigid and complained of pain upon movement. These individuals relaxed and lost these pains. With relaxation there was a reduction in

redness, steamy cornea, shallow anterior chamber, dilated pupil and high tension the tremor and they were able to be up again. The fact that 2 bedridden patients with this diagnosis could be up and about were quite amazing. We have since that time treated all patients who have athetosis or tremor by stellate ganglion block. What, at the onset, was a therapy directed toward relief of a symptom, *pain*, has now come to be a very valuable adjunct to the treatment of a disease that has been a therapeutic nightmare for centuries. We have now treated by this method 20 patients with Parkinson's disease, 2 with athetosis and 1 whose tremor I cannot classify. There has been an improvement in each instance.

Many pain problems remain but cannot be discussed at this time. It is well to remember that pain, from whatever source, can be reasonable for reduction of life span. It is also true that when a region is made insensible to pain that certain therapies may be carried out that are prohibited by pain. Radiation therapy, mechanical cleansing and drainage of wounds are all made easier if the sites are pain free.

Most operative work designed to isolate a painful part from the thalamus and cortex is not every time cossuming. However, patients who have lesions requiring this type of surgery are generally debilitated and do not tolerate operations well, nor recover rapidly. In this surgery, as much as in any other, no matter what the field or the extent, preparations for any and all emergencies must be made. This applies not only to major procedures but to regional infiltrations and blocks as well.

FALL REFRESHER COURSE IN LARYNGOLOGY,
RHINOLOGY AND OTOTOLOGY
AT
UNIVERSITY OF ILLINOIS COLLEGE OF
MEDICINE

The University of Illinois College of Medicine announces its sixth semi-annual Refresher Course in Laryngology, Rhinology and Otology, September 24th through September 29th, 1945, at the College, in Chicago. The course is intensive and largely didactic, but some clinical instruction is also provided.

GLAUCOMA: ITS DIAGNOSIS AND MANAGEMENT

WILLIAM O. MARTIN, JR., M.D.

Atlanta

By the term glaucoma we refer to a pathologic condition of the eye in which there is increased intraocular tension. The so-called normal tension varies with different individuals. What may be normal for one eye may be abnormal for another, as evidenced by loss of vision or cupping of the disc.

The importance of glaucoma can be more fully appreciated when we realize that it is one of the commonest causes of blindness. It produces one-third of the blindness occurring after middle life. In the United States there are 20,000 people totally blind, 100,000 blind in one eye from glaucoma, and 200,000 known cases of glaucoma with perhaps many more either unrecognized or unreported.

Out of 1,249 eyes removed at the Institute of Ophthalmology of the Presbyterian Hospital, New York, 516 or 41 per cent were glaucomatous.

There are at least ten times as many cases of chronic glaucoma as acute, perhaps more, because chronic glaucoma frequently goes unrecognized, whereas acute glaucoma, because of such severe symptoms, is much more often recognized and relief sought. During the period from 1937 through 1942, there were 1,802 operations performed for glaucoma at the New York Eye and Ear Infirmary. Of these, 1,401 were for chronic glaucoma and 401 for acute glaucoma.

One of my main objects in presenting this subject is to emphasize the fact that chronic simple glaucoma is more than ten times as common as acute glaucoma, and yet may not produce any symptoms whatever until quite late.

Acute glaucoma should offer little difficulty in making a diagnosis. In general it is characterized by sudden onset of severe pain, frequently by nausea and vomiting,

with definite impairment of vision.

Chronic glaucoma offers a great deal more difficulty in making a diagnosis. The onset is insidious, with little or no pain, depending largely on the elevation of tension. There is no redness, and the anterior chamber may be of normal depth, the pupil of normal size and the vision normal. The intraocular tension may be within normal limits on occasions, but carefully taken visual fields will show alterations. There may be indefinite symptoms of so-called neuralgia, in or about the eyes, a sense of dryness, possibly impairment of light and dark adaptation, or halos around lights.

Among all the patients seeking ophthalmic advice, between 1 and 2 per cent have glaucoma, but because of the absence of symptoms even the oculist may not recognize some cases, just as early cancer may escape the notice of the general physician. All people in middle and late life should consult an oculist at periodic intervals, and not be content with buying glasses from a non-medical man. The family physician or internist should be always on the alert in suspecting glaucoma, just the same as in suspecting early cancer. If he suspects glaucoma, and refers the patient to an oculist, he should insist that the oculist definitely rule out or confirm his suspicions. To do this he must take the intraocular tension on one or more occasions, with a tonometer, and not rely on an estimation by his fingers. He must also take the visual fields very carefully. If the tension is at the upper limits of normal, doubtful or potential glaucoma may frequently become manifest, after the instillation of homatropine. If there is a rise of tension, latent glaucoma exists. The tension does not rise in the normal eye.

A glaucomatous halo is best seen when looking at a bright light from a distance in the dark. Two colored rings are always seen, an inner blue-violet and an outer yellow-red, the red tinge being on the outside, while a green ring may separate these.

Glaucoma definitely tends to run in families. It is fairly evenly divided between the sexes. It nearly always becomes bilateral eventually. It is a disease of late middle

life, and is most common in the sixth and seventh decades. It is far more common in hypermetropic eyes, although it does occur in myopic eyes. When it does it is more easily missed until a late stage, partly because the tension frequently remains relatively low, and partly because the appearance of the disc is misinterpreted as being due to the atrophy accompanying myopic changes.

The visual acuity in chronic glaucoma may remain unimpaired for a very long time — long after the visual field has suffered severely. Weakness of accommodation and an early and rapidly increasing presbyopia, suggest beginning glaucoma. In the more advanced stages of the disease, the vision fails owing to retinal ischemia and degeneration and atrophy of the optic nerve.

In simple glaucoma, especially in its earlier stages, perimetry is a most valuable method of investigation, not only to establish the presence of the disease but also to measure its progress, and assess the value of treatment. Glaucomatous fields are more or less characteristic: Rönne's nasal step, Bjerrum's scotoma, sector defects, Seidel's sign, etc.

The optic nerve shows cupping after the disease has existed for some time and is one of the primary diagnostic features of the disease. It is due to atrophy of the nerve fibers and ectasia of the disc. One should never wait for definite glaucomatous cupping before a diagnosis of glaucoma is made, however.

Intraocular tension is one of the important diagnostic aids. A normal or subnormal tension, on one or more occasions, is no criterion that glaucoma does not exist. An investigation of the diurnal variation in tension over a period of several days should be made. It is higher on arising in the morning than in the evening. Several theories have been advanced as to the explanation of this. If there is a variation of 10 mm. of Hg (Schiötz) it is indicative of latent glaucoma. If there is a rise of tension of 6 mm. of Hg (Schiötz) after being in a dark room for an hour it is pathologic; and the same applies to lying down,

(Continued on page 140)

THE PRESIDENT'S PAGE

"PERHAPS THE WORD 'RECIPROCITY' WILL DO"

"Spring housecleanings" are falling late this year. What with the extra demands on the responsible members of the family, and the difficulty of getting help of any sort, that refreshing ritual of the physical home has been delayed. The window panes are cloudy and rainsplashed; the attic and basement are cluttered.

The terrible complications of present-day living have forced the curtailment of many of the gracious gestures of human intercourse, especially hospitality, with its tender amenities. In fact, the war has spun us all into an accelerating rush that makes us giddy and insensitive to each other.

Now you surmise the point: it is "cleaning up" time in our ethical practices! Ever and anon we need to check our attitudes and professional habits, even in normal times; today

"When from our better selves we have too long
Been parted by this hurrying world."

we need to electrocardiogram our doctor heart, burdened as it is with irritations, anxieties, and overwork, to estimate its honesty, sincerity and generosity toward our fellow practitioner. The best of us may let dirty habits accumulate. And unless we check ourselves, the layman will step up to do it for us, putting a red mark by our every deceit.

The "golden rule" is the measure for medical ethics, as it is for all good behavior, not only setting the standard for our treatment of each other but first and foremost toward our patients. Many may have fallen into "low aim" during this wartime period of emergency and inflation that never before have conceived of the slightest breach. As I said before, the rush of it all may have deadened our sensibilities to the amenities that keep us in the right mood toward each other.

Any business transaction that is not mutually advantageous is immoral and unethical. By the greatest stretch of the conscience we can find no advantage to the patient whose doctor refers her for consultation where he benefits more than she. "Fee splitting" is by no means the worst crime practiced. Many of us "not for sale" might more subtly "buy" a fellow prae-

tioner's referred cases. No fees would he deign to give, yet might make just the unkind, uncalled-for criticisms of others that would court the practice rightfully belonging elsewhere.

And are we allowing our manners to rust in the matter of letter-writing? Any doctor who has enough confidence in another to refer his cases is entitled to some sort of report, not only because he is interested but for the future good of the patient. This bad habit has taken hold of some of us pretty strongly during these unaccountable days, and is ethically a little "in the red." We must plan to cure it when we can get to the typewriter more regularly; and to save our souls now we should possibly use the telephone frequently, else we should not blame the doctor for referring the patient *further* next time.

There is no need to mention the man who cheapens himself in the eyes of his fellow practitioners, and certainly in the layman's estimate, by cutting prices. We are all hard to satisfy — we are human beings, wanting more than our shares — but the one guilty of price-cutting sears his own pride, and invites indiscriminating patients by his compromise.

If we draw close together now and come down to the fine points in ethics, we must acknowledge that we are cheating each other by withholding the encouraging word that we think, but say not, and the recognition that is due a deserving comrade. By profession we are the subjects of much harsh criticism and unkind judgment by the layman. A doctor learns early in his practice to meet with rebuffs; to have his personal and professional deeds on the public tongue. The more then do we need the praise of our kind.

"The love of praise, howe'er concealed by art,
Reigns more or less, and gloks in every heart."

The French Moliere said, in estimating human conduct: "If everyone were clothed with *integrity*, if every heart were frank, just, kindly, the other virtues would be well nigh useless." But in a far earlier day, the great old Prophet Confucius deduced that "What a true man does not want done unto himself, he does not to others." When asked, "Is there one single word that can serve as a principle of conduct for life?" he replied: "Perhaps the word 'reciprocity' will do."

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

JULY, 1945

COOPERATIVE EFFORT NEEDED

Today presents an opportunity for allied interests and efforts. We read, speak of, and think about our allies. As a profession are we isolationists in thought and action? If so, can we live alone? Many believe we cannot in medicine any more than we can economically. It is my opinion that the dentists, pharmacists, nurses and veterinarians have many things in common with us. Medicine as a profession has progressed steadily since the "Horse and Buggy Days" — so it may be said of the other professional groups. The dental profession has improved its methods and raised high its standards. The druggists have a four-year course of instruction, and high qualifications for entrance. Nursing standards, courses of instruction and entrance qualifications have been elevated and today they hold a pre-eminent position in the professional world. One could make much favorable comment on the progress of the veterinarians. They treat our sick and injured animals, but they do much more. They have added to our knowledge about tuberculosis, undulant fever and other equally important diseases. They inspect much of our meat and many of our dairy herds. They have often made substantial contributions by sponsoring legislation for the benefit of humanity. The public is dependent on each of these groups for the solution of their health problems. Jointly they mean the power for promotion of a better and more progressive health program. Who is the physician that is not made more intelligent, more ethical, and even happier if he maintains good relationships with the pharmacist?

No physician, urban or otherwise, can do his best work without aid from the nursing profession. Again, may we ask who would try to practice modern medicine

without access to members of the dental profession? Can anyone deny that a program of mutual assistance between these allied groups would not be a real contribution to all the people?

Some few states have formed an organization composed of a small number of representatives (usually two to five) selected from each official state society or association and including personnel from the State Board of Health. This interallied group, or council, holds an annual meeting at which are discussed mutual health problems, legislation, etc. In some instances programs, or legislation, are jointly sponsored. The representatives at this meeting may return to their respective state meetings of their associations, or societies, and report their findings. In this manner each state group could be properly informed as to the desires and policies of the others and by so doing could disseminate information that would be very helpful. In the matter of legislation, when a program has been adopted by all of the associations, or societies, this would materially strengthen our forces for sponsorship of laws. The success of this allied council, or group, would depend largely on each state organization sending its delegates to the annual meeting of each of the other groups. Great profit would inevitably come from this mingling together which would make for a better understanding. The activities of mutual interest then could be reported back for study and action and as the years passed our common objectives could be accomplished with greater ease and more satisfaction. To me the greatest benefit would come from joint sponsorship of all the things for the good of the people, and combined action for the defeat of proposed laws that would be detrimental to all the people.

The Medical Association of Georgia might take the lead and ask the president of each state group to name the delegates for the first joint meeting. The advisability of a permanent organization might be discussed and plans laid for the continuance of this program.

C. C. AVEN, M.D.

POLIOMYELITIS

On the eve of infantile paralysis summer outbreaks, a recapitulation of the figures available, show that the number of poliomyelitis cases in the country is running about 50 per cent ahead of a year ago, according to Dr. Don W. Gudakunst, Medical Director of The National Foundation for Infantile Paralysis, Inc. As of mid-May, the number of new cases this year were 642 as compared with 424 cases for the same period in 1944.

Sharp increases have been reported in the New England states, Middle Atlantic states, South Atlantic area, and the East South Central states. In the Pacific Coast and West South Central areas which have been hard hit during the past two years, there has been a noticeable drop in the number of new cases. The remainder of the country is running about the same as last year.

While the fact that there are 50 per cent more cases in the country this year than in the same period in 1944, "this is not an alarming situation but it should be watched carefully," said Dr. Gudakunst. He also declared that "The National Foundation, based on its experience of assisting in severe outbreaks of infantile paralysis during the past years, is in splendid condition to render real service to medical and public health authorities in an epidemic of infantile paralysis wherever it may occur. We stand ready and willing to help the state, county, and local health authorities at a moment's notice."

As a further aid in the fight against infantile paralysis, the National Foundation is distributing hundreds of thousands of bulletins entitled "When Polio Strikes," which includes many helpful hints for parents. It also contains a series of simple precautions to be taken by parents during the summer months.

GENERAL BAYNE-JONES EMPHASIZES IMPORTANCE OF RESEARCH ON NATIONAL SCALE

"Experience of the past and vision of the future clearly show the need for organization, coordination and support of medical research, as of all scientific research, on a national scale," said Brigadier General Stanhope Bayne-Jones, U.S.A., Deputy Chief of the Preventive Medicine Service, Office of The Surgeon General, in a recent address at the semi-centennial celebration of the Yale Chapter of Sigma Xi at New Haven, Conn.

Citing control of the typhus fever epidemic at Naples through the use of DDT, General Bayne-Jones stated that "the synthesis of a half a dozen sciences is in a single puff of DDT powder."

He said that planning is now being made for post-war research but "when the compelling

necessities of the war end and the urge of patriotism diminishes, there probably will not be the same degree of motivation toward group work for the solution of scientific problems."

He added that funds and laboratories may be made available but stressed the need to arouse or keep at high pitch in post-war years the present spirit of collaboration and intense application.

SHALL PENICILLIN BECOME PROPRIETARY?

Questioning the advisability of restricting sale of penicillin to prescriptions, Dr. Frederick J. Cullen, executive vice-president of the Proprietary Association of America, in the current bulletin to members, notes that "ample control is assured over the products of this type that are to be distributed to the general public."

At the same time Dr. Cullen urges the industry not to advertise and exploit penicillin in the manner of vitamins.

"Some of the states are attempting to enact legislation which will restrict the sale of penicillin to prescriptions" the bulletin states. "I do not feel that penicillin should be used in proprietary products and then advertised and exploited in the manner that vitamins, for example, have, but is there any good reason why penicillin should be restricted? There has been no evidence made available to show that penicillin is dangerous, regardless of the size of the dosage. Might not this drug be of value in self-medication in preventing the spread of various types of diseases, and thus help in maintaining public health and in building resistance against disease?"

"Penicillin has been given consideration by the Federal Food and Drug Administration under the provisions of Section 505 (the new drug section) of the Federal Act, and preparations that are placed on the market containing penicillin will also have to be considered under this section. Therefore, we feel that ample control is assured over the products of this type that are to be distributed to the general public. To deny this contention is to reflect upon the integrity and ability of the members of the Federal Food and Drug Administration. We may safely contend that the facilities and resources available to the Federal Administrator in determining the safety of drugs exceed those available to selfishly interested groups and that a determination by the Federal Food and Drug Administration in a duly promulgated regulation or in the form of an approval of a drug application should be sufficient for the purposes of State enforcing officials."

NEW ARMY GUIDE FOR INDUSTRIAL MEDICAL PROGRAM

The Preventive Medicine Service, Office of the Surgeon General, has announced the publication of a new manual prepared by the Occupational Health Division designed to serve as a guide in standardizing the medical program of dispensaries in Army industrial installations. It is entitled, "Operating Procedures for Industrial Dispensaries."

GLAUCOMA: ITS DIAGNOSIS AND MANAGEMENT

(Continued from page 136)

particularly with the head low, for an hour. These two tests may be combined to accentuate the combined effect. In the glaucomatous eye there is a rise in tension after drinking one or two cups of strong coffee; in the normal eye there is no variation. Mydriasis will raise the tension in the glaucomatous eye but not in the normal eye.

Treatment

The treatment of primary glaucoma must still be considered very unsatisfactory, although we have made considerable progress.

In general terms, treatment consists of attempting to correct the patient's hygiene and habits and counteracting any constitutional diathesis, while at the same time maintaining the tension of the eye within normal limits by medicinal methods. If these fail and the tension remains high, or shows a dangerous instability, or if a deterioration of function persists, operative measures must be undertaken for its relief.

Miotics: Pilocarpine in $\frac{1}{2}$ to 2 per cent solution is the sheet-anchor. It should be used in the smallest doses which produce adequate miosis and at intervals which allow it to control the highest levels in the tension. Thus the usual morning rise may be combatted by a drop at night, and another on waking in the morning, as well as after the fatigue of the day's work.

Eserine (physostigmine) is a more powerful miotic than pilocarpine, but should not be used over a long period of time because it frequently produces a quiet, plastic iritis with synechiae.

Adrenalin and its by-products, especially the synthetic epinephrine bitartrate in a 2 per cent solution or ointment, may be of aid in chronic simple glaucoma but never in acute congestive or hemorrhagic glaucoma. It is especially efficacious in secondary glaucoma in that it breaks up posterior synechiae as well as reduces the tension.

Mild or weak saline laxatives should be used along with miotics, for their dehydrating as well as laxative effect.

Freedom from anxiety and worry is important. Anxiety neurosis, especially in persons whose parents or relatives have

glaucoma, should be combatted. An acute attack of glaucoma in an individual with potential or latent glaucoma may be produced by emotional disturbances or nervous tension.

Reese,¹ in an excellent survey, emphasizes the importance of early operation in chronic primary glaucoma.

The same importance should be attached to the early recognition of and the early operation when indicated for glaucoma as is generally conceded for cancer. Too frequently the patient and physician procrastinate when an operation is indicated. The operation may be deferred until the disease has advanced too far to be arrested, then repeated operations fail and glaucoma is branded incurable.

The operations most often performed are iridectomy, corneo-scleral trephining as advocated by Elliott, LaGrange's sclerectomized iridectomy, cyclodialysis, and the iris-inclusion operations. Each has its sponsors and advantages, and certain indications. Generally speaking, a filtering operation is indicated in chronic simple glaucoma, and Elliott's corneo-scleral trephining is perhaps the operation most generally employed. Cyclodialysis has certain definite indications because it is easy to perform and has few complications. It can be repeated several times and can be followed by any other operation. It is especially useful in cases in which the tension is not high.

Conclusion and Summary

Glaucoma is responsible for one-third of the blindness occurring in middle life. We must cease to think of glaucoma as occurring mainly in acute attacks, with severe pain, etc., because the chronic type is far more common and is too often unrecognized. When medicinal measures fail, early operation is imperative, otherwise changes occur which cannot be corrected by any means. If glaucoma is allowed to progress to a stage where there is definite cupping and marked loss of visual field the prognosis is unfavorable regardless of treatment.

I wish to express my appreciation to Dr. A. B. Reese for the slides shown.

1. Reese, A. B.: The Value of Early Operation in Chronic Primary Glaucoma, J. A. M. A. 113: 1204-06 (Sept. 23) 1929.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.

President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.

First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.

Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.

Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.

Corresponding Secretary—Mrs. Alex Russell, Winder.

Treasurer—Mrs. Ralph Fowler, Marietta.

Historian—Mrs. W. W. Puett, Norcross.

Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.

Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

The Auxiliary to the Georgia Medical Society met at the home of Mrs. Lee Howard, Savannah, for its June meeting. The meeting was called to order by the president, after which the Lord's Prayer was prayed in unison.

Mrs. Lee Howard moved that another \$50.00 be added to the sinking fund, which motion was seconded and carried. The illness of two members was reported: Mrs. G. H. Lang and Mrs. John Howard.

A letter was read from Mrs. Josephine Taylor, president of the Junior Board of Chatham-Savannah Tuberculosis Association, thanking the auxiliary members for their assistance in the tuberculosis street sale. A letter was read from Dr. C. A. Henderson inviting the auxiliary members to attend a lecture by Dr. Walter Wilkins, medical nutritionist of the U. S. Public Health Service, to be held at the Health Clinic June 15 from 10 A.M. to 1 P.M., and the afternoon session conducted by Miss Lurline Collier from 2:30 to 4 P.M. Mrs. Charles D. Center, of the U. S. Public Health Department, issued an invitation to the auxiliary to attend the Savannah-Chatham County Social Hygiene Conference to be held at the DeSoto Hotel June 12. The auxiliary voted to invite Mrs. Frank Boland, wife of Dr. Frank K. Boland, Chairman of the Board of Directors, Georgia Social Hygiene Council, to be its guest at the luncheon of the Social Hygiene Conference.

A new member, Mrs. Ravenel Redmond, was introduced to the auxiliary. The meeting adjourned at 12 M.

Mrs. Eustace A. Allen, first vice-president, and chairman of organization, of the Auxiliary to the American Medical Association, has the following interesting message to auxiliary members throughout the nation. This message recently appeared in *The Bulletin of the Woman's Auxiliary to the American Medical Association*:

For any organization to survive there should be individual responsibility—a body of persons united for a specific purpose. One of the objects of our auxiliary is to increase friendlier relations between the families of physicians and between the medical profession and the laity. The measure of our success depends upon the unified and coordinated support of all members. It means cooperation and recognizing the rights of others. It is a direct appeal to the best that is in us and our fellowman.

Today every organization realizes the need of postwar planning for the continuation of progress and improvement of mankind. Never has there been a time when cooperation was needed more than today. This is a time of interruptions and changes in the steady development of life toward a common consciousness and a common will. It is hoped that these changes will open man's eyes to a fresh aspect of the possibility of a unified world, a world with one thought in mind—the outlawing of war. This is not merely a moral and social revolution but a trend of the most obvious kind, the coordination of all nations of the world.

One great purpose of this war is to change, to fuse and to enlarge all human life. This war has affected the life of everyone, some more than others. There will be more changes and adjustments necessary with the return of our armed forces to civilian life. We hope very shortly there will be coming back to every community the physicians who have served in the armed forces and with them their wives; some of whom have never been members of the auxiliary while others will be strangers to the locality. These wives have served as good soldiers themselves, in many instances breaking up their comfortable homes to be with their physician husbands as long as possible or they have taken up defense work to aid in the war effort. We as the wives of those who have served on the homefront have a responsibility in upholding the ideals of our auxiliary. This can best be accomplished by making this a year of personal service, by showing these prospective members sincere interest, friendliness and imparting to them the importance and advantage of being an auxiliary member. Much help and cooperation can be given in seeing that they are comfortably located and also in introducing them to the community. Let us show them that we are united in truth as well as in spirit for the purposes for which our auxiliary was founded.

And last, gaining new friends is mining the richness of life. It is the flowering of our own respect to be gracious to new opportunities and new acquaintances. We have different names, different environments, different social experiences, but in our service to the medical profession and medical arts we may all be one and, together in this oneness, seek that fellowship which as gentlewomen we shall always welcome.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALNUT 8911; residence, JACKSON 7979.

SELECTION OF STUDENTS FOR THE SCHOOL OF NURSING

CARRIE M. SPURGEON, R.N.
Educational Supervisor,

Board of Examiners of Nurses for Georgia
Atlanta

In the modern school of nursing the responsibility for selecting students after gathering and evaluating credentials and pertinent information showing aptitudes and abilities of applicants rests with a committee on admissions. This committee is appointed by the school of nursing faculty, and functions according to the school of nursing policies and standards in choosing only the applicants whose background and special qualifications have fitted her to undertake the level of instruction offered by the schools. The need for a close working relationship between the faculty and the committee on admissions is well expressed by the Committee on Measurement and Educational Guidance of the National League of Nursing Education in the following comment:

The standards of admission to the school must of necessity be adjusted to the level of instruction within the school and neither of these standards can be altered without necessitating corresponding adjustments in the other. Whatever the aims of the faculty of the school, the actual level of instruction can never exceed the level of ability of the students. If the course is to be on a professional level, only candidates with ability to master such a program should be admitted to the school.

What qualities should the school of nursing demand of the prospective student and how may the presence or absence of potential abilities for nursing be estimated before the student is accepted into the school? In the main the school seeks to evaluate intellectual capacity, educational achievement, cultural background, manipulative skills, interest, personality characteristics, and physical fitness. Much time, expense and unhappiness for the school and for the student may be averted by careful consideration of all available data which might aid in predicting the success or failure of the applicant.

The score on a standardized test showing

scholastic aptitude or the ability to learn is considered by the committee in relation to the results of the personal interview, letters of reference from previous employers, the personal data record, health record, college and high school credits, and results of standardized tests of educational achievement. Sound inferences may be drawn relative to the individual's learning power, educational achievement, special aptitudes for nursing, mental alertness, ability to present ideas, judgment, voice, appearance, self-confidence, friendliness, emotional and social maturity only after a careful evaluation of all accessible data has been made. Descriptions of specific tests used for pre-nursing students may be found in Triggs, Frances O., *Personnel Work in Schools of Nursing*, W. B. Saunders Co., 1945, pp. 156-166. Some information relative to mechanical skills may be gained from the evaluation of past successes in vocational opportunities requiring manipulative ability. Existing tests of mechanical ability have not been found to offer an accurate prediction of success in nursing skills, and the Psychological Corporation is conducting research in this area at the present time. The health status of the applicant is usually verified by a physical examination by medical officers of the hospital which conducts the school or with which the school is connected. The value of interest and personality tests in the selective process is still under question since it is rarely probable that reliable responses are made but more likely those which the applicant believes will lead to acceptance into the school. Past experience shown on the personal data record, however, do give an indication of interest and personality where activities engaged in are voluntary. The committee is therefore interested in the applicant's record of her participation in areas of music, literature, art, travel, athletics, special group activities, in opportunities for leadership, and in her interest shown in social, economic, and religious activities.

The committee on admissions considers each applicant in relation to the school of nursing requirements with special reference to evidence of the strengths in areas essential to the nursing course. A weakness may be found which can

be pointed out to the applicant for correction before admission. A low score in reading, spelling, or mathematics may not necessarily indicate a low level of intellectual capacity, but rather the result of poor habits. By thorough testing this fact can be discovered and remedies may be applied in time to salvage a promising student. On the other hand, the student whose test results, records, and personal evaluation do not indicate an outlook for success in nursing may be guided into another field.

The Georgia schools of nursing are showing increased interest in improved evaluation methods and in the use of pre-nursing tests for the selection of students. Ten of the seventeen schools are now having applicants tested before admission, the length of time prior to the admission date varying from three days to six months. Three schools test their students after acceptance, and in such cases the results of the tests may be used for purposes of guidance of the student during the nursing course.

Schools of nursing over the country are giving greater recognition to the importance of admitting only those students whose tested qualities show fitness and potentialities for success in the nursing field. The need for a clearer definition and finer measures of qualities needed for success in nursing is recognized and it is hoped that research which is being done in this area by schools and national committees at present will bring helpful results. Those schools which are using the best known methods of selection are already finding some conservation of education resources and achievement of a richer total program in nursing.

MEDICO-LEGAL CONFERENCE AND SEMINAR

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present (Oct. 1-6, 1945) a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend.

Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

"COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Through the cooperation of Mead Johnson Company, \$34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art work best illustrating the above title.

This contest is open to members of the American Physicians Art Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, Cal., or Mead Johnson & Co., Evansville 21, Ind.

PUBLIC WARNED THAT PENICILLIN IS NOT "CURE-ALL"

A warning that penicillin is not a "cure-all" is made by Francis E. Fronczak, M.D., health commissioner of Buffalo, N. Y.

"The public today is being misguided into thinking that penicillin, the new so-called miracle drug, is a cure for all ailments," Dr. Fronczak says. "That, of course, is not true. But dramatic reports of cures in cases of gonorrhea, syphilis, blood poisoning and pneumonia have led the thoughtless to vain conclusions.

"Penicillin in the hands of trained physicians is an important addition to the medical armamentarium, but it must not be considered a cure-all."

Meanwhile, with utmost care, makers of packaged medicines are engaged in exhaustive scientific research to bring to the public forms of penicillin which can be useful and available for over-the-counter purchase in drug stores. Now that the drug is being released generally for civilians on doctors' prescriptions, this research will be intensified.

Penicillin ointment may well be the first packaged medicine to be developed by this research. Several scientific papers have also appeared on preparations of penicillin taken orally and held in the mouth in the form been reported to be remarkably beneficial. Penicillin is also said to be dramatically effective for trench mouth, and the ointments in laboratory and clinical tests, as yet incomplete, give promise of effectiveness in treatment of skin infections.

ARMY MEDICAL LIBRARY APPOINTMENTS

The Army Medical Library has appointed Mr. Wyllis Eaton Wright of New York City as The Librarian (a newly created Civil Service position), and Miss M. Ruth MacDonald of Detroit, Mich., as Chief of the Catalog Division and Head Cataloger, according to the Office of the Surgeon General.

Mr. Wright has been associated with the New York Public Library since 1927, for the past nine years as Chief Cataloger. For three years he was Librarian at the American Academy in Rome. He was also Assistant in the library of Williams College from which he was graduated in Arts and took his master's degree in 1926. He is the author of a number of works connected with cataloging and the history of cataloging; has been president of the New York Library Club; and has served on many committees of the American Library Association, including the Committee on Aid to Libraries in War Areas, of which he is now chairman.

Miss MacDonald, who is one of the outstanding cataloging administrators in the country, was Head Cataloger at the Detroit Public Library. She was graduated in Arts and Library Science from the University of Washington in her native state of Washington. She then held the successive positions of Assistant Librarian and Cataloger at Reed College, Assistant Cataloger at Columbia University, and Cataloger at the Public Library at Seattle, Washington. She was associated with the University of Idaho library for four years, and was Cataloging Librarian at the University of Washington.

NEWS ITEMS

Members of the Newton County Medical Society were guests of Dr. W. D. Travis for dinner at the Delaney Hotel, Covington, at their June meeting. Dr. Travis was recently elected president of the society he had served as secretary-treasurer for 39 years. Dr. J. B. Mitchell of Porterdale was elected secretary-treasurer.

The Third District Medical Society held its annual meeting at Cherokee Lodge, Columbus, May 31. Dr. Bruce Threatte, president of the Muscogee County Medical Society, presided. After extending a hearty welcome to the 75 physicians and surgeons present, he appointed the following nominating committee: Dr. J. C. Patterson, Dr. J. L. Spikes, and Dr. R. C. Montgomery. Scientific program: "Measures of Relief from Pain in Obstetrics," Dr. B. Hartwell Boyd, Atlanta; "Treatment of Morphine Addiction," Dr. Joseph C. Massee, Atlanta; "The Newer Insulins," Dr. Ebert Van Buren, Atlanta; "The Protein Intake and Wound Healing," Dr. Sidney C. Madden, Atlanta; "Cancer of the Cervix Uteri," Dr. J. Elliott Scarborough, Atlanta; "Biological False Positive Tests for Syphilis," Dr. Albert Heyman, Atlanta; "X-ray Diagnosis of the Acute Abdomen," Dr. H. S. Weens, Atlanta; "Bacteremia," Dr. Paul B. Beeson, Atlanta; "Diagnosis of Brain Tumors," Dr. Edgar F. Fincher, Atlanta; "Studies on the Circulation Using the Technic of Venous Catheterization," Dr. Eugene A. Stead, Jr., Atlanta. Dr. Cleveland Thompson, Millen, president of the Medical Association of Georgia, addressed the group briefly. The following officers were elected: Dr. Willis P. Jordan, Sr., of Columbus, president; Dr. Herschel A. Smith, of Americus, vice-president; Dr. Walter Gus Elliott, of Cuthbert, secretary-treasurer; Dr. Steve Kenyon, of Dawson, counselor; Dr. Guy Dillard, of Columbus, vice-counselor. Following Dr. Kenyon's announcement that it is mandatory for the Third District Society to recommend to the governor the names of two men to represent the Third District on the Georgia Board of Health, Dr. R. C. Montgomery, of Butler, and Dr. J. C. Patterson, of Cuthbert, were nominated. Governor Ellis Arnall will select one of them to fill the position. The visiting physicians were guests of the Muscogee County Medical Society at dinner following the program.

The Richmond County Medical Society held its regular meeting at the American Legion Post on Milledge Road, Augusta, May 17. Dr. Harold P. McDonald, of Atlanta, spoke on "Obstructive Lesions of the Urinary Tract." Dr. Richard P. Harrell, secretary-treasurer of the Richmond County Medical Society, invited all physicians in the territory around Augusta to attend the meeting.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, June 12. Dr. George Touchton, president, introduced Dr. Frank K. Boland, of Atlanta, professor of surgery at Emory University, as guest speaker. His subject was "Surgery of the Chest at the Grady Hospital, Atlanta." Dr. Boland, who is one of the South's outstanding surgeons, has been prominent in work of many Southern medical organizations. He is past president of the Medical Association of Georgia, the Southern Surgical Congress and the Southern Medical Association. He is now chair-

man of the board of directors of the Georgia Social Hygiene Council. In this connection he presided over the luncheon session of the Savannah-Chatham County Social Hygiene Conference in the main dining room of the Hotel DeSoto. The program was arranged by Dr. Emerson Ham, assistant city-county health officer.

The Chatham-Savannah Health Council met recently at the auditorium of Armstrong Junior College, Savannah. Charles M. Maclean, chairman of the committee on education of the council, in making the announcement, said Dr. W. P. Beckman, psychiatrist of Columbia, S. C., was a distinguished expert who spoke on "Every-Day Adjustment in Every-Day Families in the Field of Mental Hygiene." Following the talk an open forum was held and the audience's questions were answered with expert advice given on problems presented. The meetings are open to the general public.

Dr. Courtenay Brooks, a graduate of Emory University School of Medicine, has chosen Washington, Wilkes County, as the place in which he and Mrs. Brooks wish to live. Dr. Brooks has leased the one-story brick office building on Spring Street directly across from Dr. R. G. Stephens, which places five physicians on "Doctors Row," where he will practice.

Dr. Glenn E. Seymour of Albany is now associated with Coleman Sanatorium, Eastman. He attended the University of Georgia School of Medicine and interned at the Baptist Memorial Hospital, Memphis, Tenn., where he was house surgeon for two years. He holds junior fellowship in the American College of Surgeons.

Lt. John C. Howard, of Savannah, has been promoted to the rank of captain in the Medical Corps, United States Army, according to a release from the Pacific where he is serving. The husband of Mrs. Marie Howard, and the son of Dr. and Mrs. Lee Howard, Captain Howard is commanding a medical detachment attached to the Casual Depot, Central Pacific Base Command.

The Obstetrical Staff of the Crawford W. Long Memorial Hospital held its regular meeting at the auditorium of the Nurses' Home, 557 West Peachtree Street, Atlanta, June 6. Dr. John J. Thomas, Professor Emeritus of Obstetrics at Western Reserve University, Cleveland, Ohio, spoke on "The Five Most Common Obstetrical Errors."

The Whitfield County Medical Society held its regular meeting at the Hamilton Memorial Hospital, Dalton, May 23. Dr. H. E. Crow of the State Tuberculosis Sanatorium, Alto, discussed "The Care of the Tuberculosis Patients, Including the Different Types of Treatment Given At the Sanatorium." The society enjoyed having Dr. Crow, also the discussion which followed the presentation of the subject. Dr. C. W. Stephenson, of Ringgold, was a guest.

The Baldwin County Medical Society, Milledgeville, held its regular meeting June 9. The meeting was called to order by the president, Dr. Z. S. Sikes. Drs. J. D. Combs, George Greene and M. F. Nunez were visitors. Dr. J. D. Combs, new addition to the Milledgeville State Hospital Medical Staff, was welcomed to Baldwin County Medical Society as a new member. Dr. Y. H. Yarbro, of

introduced the speaker of the evening, Dr. Samuel W. Hamilton, mental hospital adviser for the U. S. Public Health Service, who spoke on "What a Good Mental Hospital Should Be." The members of the society asked various questions and, as a result, there was a general discussion of the many problems in psychiatry peculiar to Georgia.

The American College of Radiology announces that they have moved to their new headquarters at 20 North Wacker Drive, Chicago 6, Illinois.

Dr. Mayes Gober, retired Marietta surgeon, has moved to his 700 acre farm at Noontootla Creek, Fannin County, Georgia, and has regained his health.

The Board of Directors of the Augusta-Richmond Tuberculosis Association, Augusta, met recently at the Georgia Power Company auditorium. Dr. William A. Doppler, of the National Tuberculosis Association of New York, was guest speaker. A special invitation was extended to representatives of industries in the Augusta area to attend the meeting, as Dr. Doppler spoke on the control of tuberculosis in industry through the combined efforts of employers, employees, the medical profession, and official agencies. Dr. Doppler, a Californian by birth, received his degree as Doctor of Philosophy from the University of Zurich, Switzerland. He is a fellow of the American Public Health Association, the American Association for the Advancement of Science, and the American Adult Education Association. More than 45,000,000 copies of his numerous pamphlets on tuberculosis have been distributed.

The University of Georgia School of Medicine, Augusta, commencement exercises were held at the Municipal Auditorium Music Hall, June 11, for the graduating class of 66 students. Dr. Edward J. McCormick, of Toledo, Ohio, delivered the principal address.

The Whitfield County Medical Society held its regular meeting at the Hamilton Memorial Hospital, Dalton, June 20. Dr. D. Isbell, of Chattanooga, Tenn., discussed "The General Practitioner's Viewpoint of Eye, Ear, Nose and Throat Practice." Dr. Isbell presented lantern slides in connection with his address.

Emory University School of Medicine, Atlanta, held its commencement in Glenn Memorial Amphitheater, June 16. Colonel LeRoy W. Nichols, director of the Army Specialized Training Division, Fourth Service Command, delivered the commencement address. Following presentation of degrees, 43 army trainees received commissions as first lieutenants; 13 Navy trainees were commissioned by Captain Robert Strite, U. S. N. R., commanding officer of the Navy V-12 Unit.

The Blakiston Company, 1012 Walnut Street, Philadelphia, Pennsylvania, publishers in the following fields: Medicine, Pharmacy, Dentistry, Biology, Plant Sciences, Hygiene, Chemistry, Physics, Astronomy and Mathematics, announces the appointment of James P. Lackey, Ph.D., as editor of undergraduate subjects in the sciences.

Dr. F. M. Mullino, Montezuma, celebrating his fifty-second anniversary as a practicing physician, enumerated

many of the changes which he had noted during this period in the city of his adoption. In review, there is charm in the old days, but Dr. Mullino has kept pace with the modern tempo and is proud of the two well equipped hospitals that have taken over the labors of the faithful practitioners of a half-century ago.

Dr. E. Vernon Mastin, St. Louis, who was elected vice-president of the Southern Medical Association at the last annual meeting, became president of the association upon the death of Dr. Edgar G. Ballenger, Atlanta.

The Fulton County Medical Society dinner meeting was held at the Academy of Medicine, Atlanta, July 5. Program: "Addison's Disease — Case Report from Piedmont Hospital," Dr. F. Levering Neely; "A Malarial Study on Island X in the Pacific," Lt. Dixon Fowler, M.C., U.S.N.R. Discussor: Major Wm. S. Boyd, U. S. P. H. S.

Major Charles Rieser, Atlanta urologist, who has been in service approximately three years, is home. He has been overseas nearly two years, and was attached to the First General Hospital in England and moved with it into France shortly after D-Day.

Major Theodore M. Yates, Augusta physician, serves in China. He commands a U. S. Field Hospital and is with an American medical liaison unit serving with the Chinese army.

OBITUARY

Dr. George Ollie Allen, aged 73, widely known Marietta physician, died at his home after several weeks' illness following a heart attack May 26, 1945. A native of Mabelton, he was the son of the late Mr. and Mrs. J. O. Allen, Cobb County pioneers.

Dr. Allen graduated from the Southern Medical College, Atlanta, in 1893, and from the University of Georgia School of Medicine, Augusta, in 1902. He practiced for a number of years at Fargo, where he was physician and surgeon for the Southern Railway Company. Upon the outbreak of World War I he entered the medical corps as a captain, serving in the Army until 1922. After taking postgraduate medicine at the New York Polyclinic Hospital, Dr. Allen entered practice at Marietta.

He was a member of the Cobb County Medical Society, having served as president of the society; the Medical Association of Georgia, the American Medical Association, the Marietta Rotary Club, the Horace Orr Post of the American Legion. Surviving are his wife, the former Miss Lora Gann, Marietta; a son, Hubert Allen, Marietta; two daughters, Mrs. Norris Dean, Marietta, and Mrs. Roy Shore, Atlanta; two sisters, Mrs. B. Z. Dodgen, and Mrs. W. A. Dodgen, both of Atlanta; three brothers, A. A. Allen, Charlotte, N. C., and J. C. Allen and H. B. Allen, of Austell, and three grandchildren.

Funeral services were held at the chapel of Mayes Ward, the Rev. George Brown and the Rev. John Tate officiating. Interment was in Mountain View Cemetery.

Dr. Edgar Garrison Ballenger, aged 68, prominent Atlanta urologist, fell seven floors to his death on the inside stairway of the Georgian Terrace Hotel, where he lived, June 1, 1945. Dr. Ballenger had complained of feeling dizzy when a Negro attendant served his breakfast in his seventh-floor room, and a few minutes later the body was found on the mezzanine floor. The detectives said it appeared that the physician had suffered a heart attack in the hall, had leaned on a banister for support and then had fallen.

Born Nov. 20, 1877, in the Blue Ridge Mountains near Tryon, N. C., Dr. Ballenger attended Furman University, the University of North Carolina, and was graduated from the University of Maryland School of Medicine, Baltimore, Md., in 1901. He served an internship at the University of Maryland Hospital and worked as company surgeon at a Maryland granite company before coming to Atlanta in 1904 to practice.

He served as president of the Fulton County Medical Society in 1911; was a member of the Medical Association of Georgia; member of the House of Delegates of the American Medical Association in 1912; during World War I served in France with rank of captain and with the Emory Base Hospital unit; later transferred to the 26th Division as urologist and remained with this division for eight months; promoted to major and remained in Germany two and one-half months with the Army of Occupation; in 1930 first president of the Southeastern Surgical Congress, which he was instrumental in organizing; fellow of the American College of Surgeons; specialist certified by the American Board of Urology; president of the Southern Medical Association, serving as member of the council from 1934 to 1939; made president of the Southeastern section of the American Urological Association in 1934-1935 and president of the association in 1938-1939; former associate professor of surgery at Emory University School of Medicine and lecturer on genito-urinary diseases and syphilis at the Atlanta School of Medicine; consulting urologist at the Grady Hospital and urologist at the Crawford W. Long Memorial Hospital; author of "Genito-Urinary Diseases and Syphilis" and contributor to section on diseases of the urethra for Oxford Loose Leaf Surgery; at one time associate editor and assistant manager of the *Atlanta Journal Record of Medicine* and on the advisory board of the *Southern Surgeon*.

Dr. Ballenger was a member of the Druid Hills Golf Club, Piedmont Driving Club, the Rotary Club, and the Sigma Alpha Epsilon Fraternity.

His wife, the former Norma Clark Gorman, of Maryland, died in 1912. Survivors are a son, Cpl. Edgar G. Ballenger, Jr., Keesler Field, Miss.; a daughter, Mrs. C. M. Foster, Atlanta; a sister, Mrs. J. B. Moseley, Atlanta; a brother, Claude W. Ballenger, Tryon, N. C.; and two grandchildren. Funeral services were held at Spring Hill, Dr. M. Ashby Jones officiating. Burial was in West View Cemetery, Atlanta.

Dr. John F. Burkhalter, aged 59, died in a Savannah hospital, May 6, 1945. He was a native of Evans County and was graduated from the University of Georgia School of Medicine, Augusta, in 1911. Dr. Burkhalter was a veteran of World War I, serving as surgeon. He was a member of the Bulloch-Candler-Evans Counties

Medical Society, and the Medical Association of Georgia. He is survived by his wife, Mrs. Ethel Williams Burkhalter; one son, John F. Burkhalter, Jr.; five daughters, Mrs. Ben T. Slade, Jr., Brunswick; Mrs. W. R. Thompson and Mrs. Jack Edwards, both of Claxton; Mrs. James A. Williamson, Charlotte, N. C.; and Miss Miriam Burkhalter, Brunswick; three brothers, H. D. Burkhalter and S. B. Burkhalter, both of Claxton, and B. B. Burkhalter, Clayton; and one sister, Mrs. Tom Edwards, Claxton. Funeral services were held at the Antioch Baptist Church near Claxton. The Rev. R. L. O'Brien of the Claxton Baptist Church officiated, assisted by the Rev. L. E. Pierce of the Claxton Methodist Church. Burial was in the church cemetery.

Dr. William T. Hinton, aged 76, Dacula, one of Gwinnett County's best known and most beloved physicians, died May 17, 1945. He had lived in Dacula all his life, where he had practiced medicine for more than fifty years.

Dr. Hinton graduated from Emory University School of Medicine, Atlanta, in 1894. He was a member of the Gwinnett County Medical Society, the Medical Association of Georgia, and the Dacula Methodist Church. Survivors include his wife, Mrs. William T. Hinton, Dacula; two daughters, Mrs. W. B. Thompson, Atlanta; Mrs. J. V. Hood, Lawrenceville; four sons, L. O. Hinton, Dacula; W. A. Hinton, Durham, N. C.; H. B. Hinton, East St. Louis, Ill.; John J. Hinton, Deland, Fla.; five brothers, J. M. and J. S. Hinton, Dacula; H. J. Hinton, Lawrenceville; H. H. Hinton, Auburn; Dr. A. L. Hinton, Orlando, Fla.; four sisters, Miss Mattie Hinton, Dacula; Mrs. David Sims, Aiken, S. C.; Mrs. A. W. Etheridge, East Point; Mrs. J. F. Mahaffey, Lawrenceville. Funeral services were held at the Dacula Methodist Church, with the Rev. Roy Donaldson officiating.

Dr. William Lester Mathews, aged 58, prominent physician of Northeast Georgia, died at his residence, Winder, May 4, 1945. He was born in old Jackson County, now Barrow, the son of the late W. E. and Almedia Maynard Mathews.

He was educated in the Winder city schools and the Atlanta College of Physicians and Surgeons, now the Emory University School of Medicine, Atlanta, in 1913. He was a member of the Jackson-Barrow Counties Medical Society, the Medical Association of Georgia, the American Legion, the Kiwanis Club, Veterans of Foreign Wars, Grand Lodge of Georgia, F. & A. M., and of the Knights Templar. Dr. Mathews was a past president of the Emory University Alumni Association. He was a veteran of World War I, having entered as a captain in the medical corps in 1916. Serving in France he attained the rank of major, receiving an honorable discharge in 1918.

He was influential in the establishment of the Barrow County Health Department and in obtaining a county nurse. Dr. Mathews was the examining physician for the Selective Service Board, surgeon for the Seaboard Air Line Railway and physician in charge of the Barrow County Health Department. Survivors include his wife, the former Miss Nellie Lou Hamby; four daughters, Mrs. Maurice Young, S 1/3 Dorothy M. Mathews, Pensacola, Fla.; Emma C. Mathews and Naomi H. Mathews.

Funeral services were held at the Winder Methodist Church, with the Rev. W. H. Clark officiating. Burial in Rose Hill Cemetery.

Dr. Walter Wesley Sessions, Sr., aged 70, prominent physician of Sumner, died at his home following a prolonged illness, May 21, 1945. Born and reared in Randolph County near Cuthbert, Dr. Sessions had practiced medicine in Worth County for many years.

He was graduated from the Atlanta School of Medicine, and later from the University of Georgia School of Medicine, Augusta, in 1911. He was a member of the Worth County Medical Society, and the Medical Association of Georgia. He is survived by his wife, the former Miss Verlin Veasy; three sons, Comdr. Carl Sessions, USN; Wesley Sessions, Cordele; W. M. Sessions, Savannah; and three daughters, Mrs. Carl Story, Cordele; Mrs. E. T. Sinclair and Mrs. J. L. Blackstock, both of Sumner; four brothers and two sisters. Funeral services were held at the Sumner Methodist Church, with the Rev. L. L. Barr, of Ty Ty, officiating, assisted by the Rev. L. W. Walker of Poulan. Interment was in Sumner cemetery.

Dr. William H. Swain, aged 76, Martin, died May 20, 1945. He was born and reared near Blairsville, and received his education at Hiwassee, Dahlonega and Atlanta. He was a graduate of the Gate City Medical College, Dallas, Texas, and the University of Georgia School of Medicine, Augusta, in 1907. Dr. Swain had lived in Stephens County twenty-three years, and was elected commissioner of Stephens County several years ago and served until his death. He was a member of the Stephens County Medical Society, the Medical Association of Georgia, Masons, and of the Confidence Methodist Church. Surviving are three sisters, Mrs. Etta Sheriff, Clarkston; Mrs. Lucinda Spivey, Blairsville, and Mrs. Eldorado Souther, Gainesville; several nieces and nephews. Funeral services were held at the Confidence Methodist Church, with the Rev. D. S. Patterson and Dr. George Shaw officiating.

SCHOLARSHIPS IN PHYSICAL THERAPY

Scholarships for training in physical therapy under the \$1,267,600 program of The National Foundation for Infantile Paralysis are available immediately for classes commencing in June and July, Basil O'Connor, president of the National Foundation, announced recently.

As a result of the increasing use of physical therapy in the treatment of infantile paralysis and other diseases, and because of the acute shortage of trained personnel, the National Foundation is offering these scholarships for nine to twelve months' courses in approved schools of physical therapy. The scholarships will cover tuition and maintenance in accordance with the student's needs.

"There are opportunities at the present time for the full employment of 5,000 additional physical therapists throughout the nation," Mr. O'Connor said. "However, present day teaching facilities at approved schools can accommodate approximately only 1,000 students. Teaching facilities at these schools will be increased by additional teachers obtained through the National Founda-

tion's teaching fellowships so that the training capacity of the schools can meet the full requirements of the profession."

Pointing out that there are only 2,500 qualified physical therapists in the United States, with more than half of them in the armed services, Mr. O'Connor said it would require several years to train the additional thousands of physical therapists needed.

"The postwar possibilities in this field are almost without limit. Physical therapy is a vocation in which there is no over-crowding and the scholarships offer opportunities for professional careers," Mr. O'Connor emphasized.

The training program will be carried out with the assistance of a special committee under the chairmanship of Dr. Irvin Abell, of Louisville, Ky., chairman of the Board of Regents of the American College of Surgeons.

Candidates for National Foundation scholarships must have two years of college, including biology and other basic sciences, or be graduates of accredited schools of nursing or physical education. Applications should be made to The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y., or to the American Physiotherapy Association, 1790 Broadway, New York 19, N. Y.

HOW "MEDICAL INTELLIGENCE" PROTECTS ARMY'S HEALTH

History has shown that most of the diseases which tend to occur in massive outbreaks in time of war are infectious diseases, and many of them follow certain geographic patterns of distribution. To prevent such outbreaks among our armies by forewarning them of the local conditions they will meet is the work of "medical intelligence."

Major Saul Jarcho, M.C., Chief of the Analysis Branch of the Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, speaking at Mt. Sinai Hospital, N. Y., cited the following example of the need for precise information concerning each individual area: "An island may be bisected by a tall range of mountains which intercepts the prevailing winds and the moisture conveyed by the winds. If this occurs one side of the island will be windy and rainy while the other may be dry and waterless. The result may be a complete difference in the occurrence of disease."

He then went on to explain that the latest accurate information available is supplied our armed forces by means of surveys conducted by Medical Intelligence officers. This information, he said, includes a brief description of climatic and geographic factors and detailed accounts of the public health organization, and medical facilities; also environmental factors such as water supply, the disposal of wastes, flora, fauna and food supplies; and information regarding diseases of military importance, potential military importance and those which affect the native population generally. Specific recommendations for the prevention and control of disease in the area are also included.

THE PHYSICIAN'S BOOKSHELF

Men Under Stress (In and After Combat) 484 Pages. \$5.00. Published June 20, 1945. The Blakiston Company, 1012 Walnut St., Philadelphia, Pa., by Lt. Col. Roy R. Grinker, M.C., Army Air Forces; formerly Fellow of the Rockefeller Foundation and Chairman of the Department of Neuropsychiatry, Michael Reese Hospital, Chicago; and Major John P. Spiegel, M.C., Army Air Forces, formerly of the Department of Psychiatry, Michael Reese Hospital, Chicago.

It is an analysis of what happens to human beings under the terrific strain of modern warfare, and an explanation of the corrective treatments, many of which have been developed in this war, by the two Army doctors who set up the first Army Air Forces convalescent hospital exclusively for "Operational Fatigue" in this country.

"Men Under Stress" records interestingly the deductions from skilled observations of the effect upon many personalities of the physical strain and emotional upheaval of battle. It describes combat fear and the many other types of neurotic disturbances and records 65 case histories in detail. The various corrective treatments are fully explained including the methods by which drugs have been used in psychiatric treatment in the late war with unusual success.

TEST FOR COLOR BLINDNESS

A simplified test for color-blindness that costs only one dollar is now available.

With the new ruling by the Civil Air Board that any recognized doctor of medicine may examine for 3rd class (private) pilots' licenses effective June 1, 1945, this inexpensive test is of greater interest to all physicians.

It is a simplified form of "A New Test for the Detection of Color Blindness," by P. B. Wiltberger, M.D., Columbus, Ohio. Omitting the discussions of the theory involved from the original publication, which first sold for \$8, the short form contains only the objective visual stimuli used in making the determination of the individual's reaction to color.

Dr. Wiltberger's test is based on physiologic reaction. It cannot be memorized and is more accurate than certain other tests.

In giving any test for color-blindness, a good strong daylight of northern exposure is required (at least 16 to 18 Weston). Between 10 a.m. and 2 p.m. is the best time. Artificial white light may be used, but the light source must be reasonably close to the test object (not

NEW PHARMACOPOEIAL HEADQUARTERS

The last Pharmacopoeial Convention, in planning for the future, authorized the Board of Trustees to maintain headquarters for the business of the Pharmacopoeia. When this question was discussed at the 1940 convention, the city of Washington was frequently referred to as a desirable location for permanent headquarters, but war conditions make Washington, at this time, wholly impracticable for the purpose.

However, with the enlarged pharmacopoeial program actively under way and with the need for increased facilities for the expanding records, files, and staff, the Board of Trustees have secured a building in Philadelphia to serve as a temporary pharmacopoeial center.

For almost twenty years the Philadelphia College of Pharmacy and Science has generously provided quarters for the Pharmacopoeial Revision chairman and his staff, and as the work has gradually expanded this has required a number of offices and considerable storage space.

The building purchased, to be used as temporary headquarters, is located at 4738 Kingsessing Avenue in Philadelphia, within a few squares of the college where some members of the U.S.P. staff have affiliations. It is a two-story, two apartment building, and will be renovated and refitted for pharmacopoeial purposes, providing adequate storage space and fireproof facilities for the protection of invaluable records of the Pharmacopoeia.

With independent headquarters established now, the foundations will be laid for permanent pharmacopoeial headquarters in Washington or in such other city as may be chosen, when the time comes for such action.

over 24 inches) and should come from over either shoulder.

The physician or person conducting the test should be normal or of the hyperchromic type. It is easy to test yourself with this new simplified form published by Long's College Book Company, Columbus 1, Ohio.

PHYSICIAN WANTED—Physician for industrial dispensary in South. Must be graduate Class A school. Please write details and give references in first letter. Expenses of interview will be arranged for satisfactory applicants. Write Medical Director, Box 590, Knoxville 5, Tennessee.



COSMETIC HAY FEVER?

Prescribe UNSCENTED AR-EX Cosmetics

Recent clinical tests showed many cases of cosmetic sensitivity, but not a single one to UNSCENTED AR-EX Cosmetics. For allergic patients, prescribe UNSCENTED AR-EX Cosmetics—free from all known irritants and allergens. SEND FOR FREE FORMULARY.

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.



FREE FORMULARY

DR. _____
ADDRESS _____
CITY _____
STATE _____

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, August, 1945

Number 8

NEUROSURGICAL ASPECTS OF LUMBAR AND SCIATIC PAIN

EDGAR F. FINCHER, M.D.

Atlanta

The etiologic factors in the lumbagosciatic syndrome are numerical, and it is not always easy in the early onset of sciatic pain to establish the specific cause. There are many orthopedic conditions that give rise to low back pain — many gynecologic situations, as well as urologic and rectal diseases — any or all of which may encroach upon the lumbar sacral nerve structures and produce pain that radiates into one or both lower extremities. The neurosurgical problems of the lumbagosciatic symptom complex would ideally be confined to two organic damages; namely, the herniated intervertebral cartilages (ruptured discs) and the spinal cord tumors within the lumbosacral canal. There are, however, many diagnostic differentiations that become the responsibilities of the neurosurgeon. The psychologic dysfunctions (compensation neuroses) constitute a very large group and, having rather common characteristics, can be discussed as a group; the remainder of the diagnostic problems for the purpose of this communication require little more than enumeration. The pertinent clinical features of the cartilage damages, the spinal cord tumors and the neuroses will be delineated somewhat in detail, the differential diagnostic group will require only brief references to the more common experiences.

The careful development of a chronological history in the lame back, sciatically handicapped patient is just as important

as it is in any other organic problem. In the intervertebral cartilage protrusions a history of a specific back sprain can be obtained in 85 per cent of the cases. From the remaining percentage one learns that activities conducive to lumbar strains have been engaged in and that a series of minor insults have laid the ground work for a cartilage damage. All cartilage ruptures are due to trauma, even if it be a violent sneezing act that actually precipitated the frank displacement. In spinal cord tumors a history of an injury may serve to make the diagnosis difficult; the trauma is entirely coincidental and is not an etiologic factor. The compensation neuroses give a specific injury in 100 per cent of the cases. In the differential diagnostic group the history of an injury is in less than 10 per cent of the cases — a pathologic vertebral collapse from a malignant invasion may be precipitated by a fall or from a heavy straining, lifting activity. The historic information in this group may furnish the lead for a diagnosis. An old pyogenic hip disease may give a history of previous sepsis. The same may be true in a tuberculous vertebral or hip joint invasion. A recent history of a boil over the buttocks or thigh may be a clue to an epidural abscess. The history of the skin eruption of a herpes zoster may help establish this diagnosis. In an elderly person with weight loss, a malignancy should be suspected. In any patient who gives a cancer history, bony secondary invasion should be strongly suspected. A history of a gunshot wound, even though years have elapsed before sciatic pain develops, can be an osteomyelitis. These are a few illustrations of personal experiences with people who have come with a very definite complaint of sciatic pain.

The onset of back pain in the cartilage damages may be acute at the time of the

From the Department of Surgery, Emory University School of Medicine.

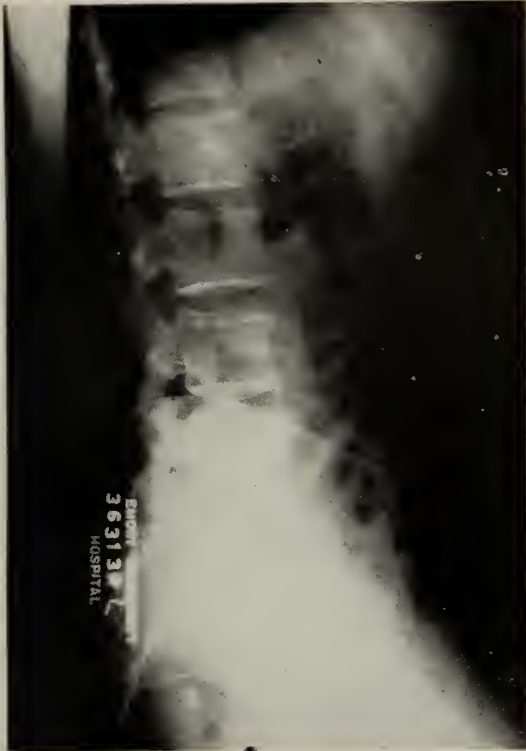


Figure 3

A loss of the normal lumbar lordosis is frequent in the ruptured disc cases. Note the narrowing of the intervertebral space between L-5 and S-1 vertebral bodies.



Figure 4

A slight scoliosis (sciatic list) is a common x-ray finding in the ruptured intervertebral cartilage.



Figure 5

The extreme sciatic torsion is usually radiologic evidence of complete incapacitation from sciatic pain of a ruptured disc.

mum in the posttherapeutic pain and in the causalgic distresses.

In the neurologic examination of the patient with a ruptured cartilage the objective evidence of nerve root irritation is in ratio to the patient's suffering. On inspection there is a straightening of the normal lumbar curve (Fig. 3) as the result of the muscle splinting of the lumbosacral erecti groups — there is an upper lumbar scoliosis—sciatic list—(Fig. 4) away from the painful extremity and one may see the dominating muscle splinting on the painful side. The "sciatic list" (Fig. 5) elevates the pelvis and gives a false impression of a shortening of the painful leg. Fibrillary twitches of the gluteal muscles are not uncommon. The greatest number of these patients walk with a limp. Calf atrophy is more likely brought out upon actual measurement of the two extremity groups than on inspection. In the spinal cord tumors one is likely to learn little or nothing on inspection. If the condition is far advanced, atrophies and contractures may have occurred. In the compensation cases bizarre positions may be assumed by the

patients, there are no involuntary muscle spasms, spine alignments are normal and oftentimes it is an ordeal both for the patient and the doctor to get them into decent position for physical examination. There are no characteristic objective evidences in the diagnostic group. The cachexia of cancer or sepsis may be very obvious. The atrophy of muscle groups may be striking. The scars from a herpes zoster are to be found.

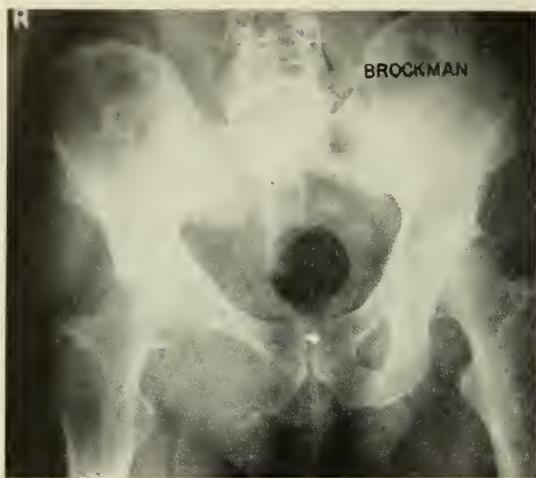


Figure 6
Sciatic incapacitation. Lymphosarcoma destruction of the ischial ramus.

Color changes are striking in the causalgic group. A tumor mass beneath the skin over the sacrum may be seen as evident cause for the low back and sciatic pain.

The motor handicaps in the ruptured cartilages are primarily the result of pain on motion and slight impairment of dorsiflexion of the foot of the involved leg is likely to be the only suggestive muscle group weakness. In the spinal cord tumors motor dysfunctions develop later in the progress of the growth and so these objective disturbances may vary from no demonstrable weaknesses to a complete paralysis of both legs. In the neuroses the motor handicaps vary from no objective paralytic evidences to a complete hysterical monoplegia. Atrophic wastings of muscle groups are always symmetrical and are entirely due to disuse. In the group for diagnostic differentiation the paralyzes and atrophies are in accordance with the duration of the spinal root or peripheral nerve damages. In a true sciatic neuritis the characteristic foot drop is always present and tibialis anticus atrophy is demonstrable. In pelvic cancer spread (Fig. 6) the muscles supplied by the femoral nerve may be more involved than the posterior muscle groups of the thighs or calves. In hip joint disease ankylosis, not muscle paralysis, may account for the loss of flexion or extension thigh function. In the greater number of these diagnostic problems it is likely that the pain from which the patient suffers confines him to his bed, not his paralytic extremities.



Figure 7
Compression fracture of the 5th lumbar body. Incapacitated left sciatica due to direct spinal nerve compression.

The changes in sensation in the cartilage damages are likely to be minimal but definitely segmental and organic in the area handicapped. In the spinal cord tumors the sensory pattern will depend on the duration of the lesion. Seen early there may be no objective sensory losses; seen later, a very definite sensory picture may be developed on skin responses to touch and pain stimulation. If such a loss has occurred, accurate localization of the level of the intradural growth can be made. In the psychologic handicaps the sensory examination will not be that of an organic character, but will be that of a sock, stocking or trouser-leg type and may even extend on up into the dorsal and cervical spinal segments, well out of any organic level that would produce low back or leg pain. In the diagnostic group, sensory examination is likely to be a normal one. If there are positive changes in sensation they will be those of a definite lumbar or sacral cord level or will conform to anatomic patterns of a specific peripheral nerve.

The reflex changes (Fig. 1) from an intervertebral cartilage damage may result in a diminution or complete destruction of the Achilles response. When absent, this

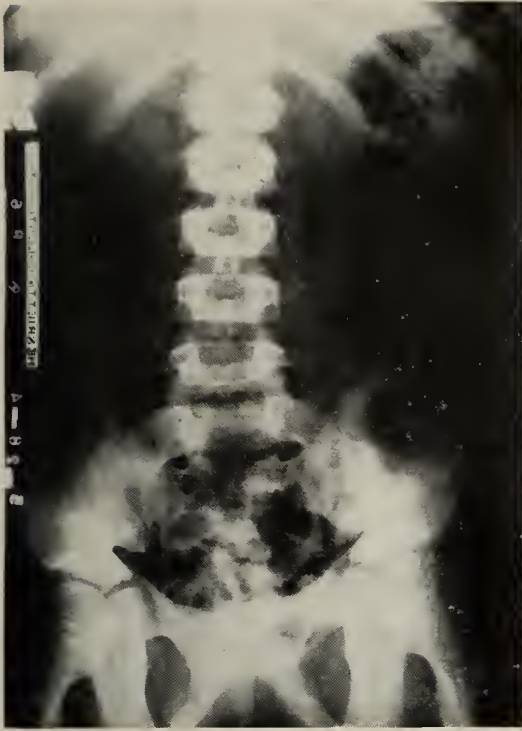


Figure 8

Spinal cord tumor L-5 level; three years bilateral sciatica. Note the widened laminal pedicles with a thinning of the 5th lumbar arch.

is indicative of a lumbosacral rupture. In spinal cord tumors, increased reflex activities are more likely and, if the tumor is located in the upper lumbar sac, pathologic toe reflexes and clonic responses may be elicited. In the compensation problems reflexes are within normal limits and no pathologic responses are to be obtained. In the differential diagnostic group reflexes are most commonly normal. The abnormal responses will be in accordance with the destructive damage of the disease to the peripheral nervous system. If the damage is peripheral the reflexes are absent; if central in location the reflexes may be normal or hyperactive.

Radiologic examination should be a part of the routine examination in the study of a lame-back-sciatic problem. Stereoscopic anteroposterior views and single lateral films are adequate views for gross review. Pathologic bony changes will determine the indication for further x-ray films. In the ruptured cartilage cases a great deal of worthy information is obtained, some of which is of negative value. These films will exclude fracture damages (Fig. 7),



Figure 9

Compensation neurosis. Spinogram. Normal spine. Note the evenness of the anterior air column, the normal lumbar curve, the normal cartilage spaces.

primary bone disease, secondary cancerous destruction, congenital defects and malpositions. In the disc cases there are three common characteristics depicted on plain roentgenologic films: (1) a straightening of the normal lumbar lordosis to give the "poker spine" picture as seen on lateral views; (2) a narrowing of the vertebral interspace at the site of the cartilage rupture; (3) the "sciatic list" of the upper lumbar spine contralateral to the painful extremity. In the primary tumors of the lumbar canal, routine x-ray studies of this area are usually normal. Where the growth has been present for a sufficient period of time a widening of the normal pedicles of the lamina (Fig. 8) may be measured. In the psychologic dysfunctions, x-ray films are normal bony depictions (Fig. 9) and the less stress laid upon the presence of some congenital anomaly of no traumatic significance the better for all parties concerned. In the differential diagnostic group, radiologic studies have their greatest diagnostic usefulness in depicting primary and secondary metastatic damages, vertebral or laminal tuberculosis, osteomyelitic vertebral disease, pyogenic hip disease, spinal injuries, arthritic damages, etc.

Radiologic visualization of the spinal

canal, following the introduction of some contrast media into the lumbar sac, is many times indicated in the radicular distresses of lumbosacral origin. Pantopaque, lipiodol (spinal), air and thorium dioxide are the more commonly used mediums for these studies. Pantopaque and air are the more desirable. The former, by virtue of its low specific gravity, can be easily recovered through the same spinal needle with which it was introduced — air because it is immediately absorbable. In the ruptured disc cases there is no necessity for visualizing the lumbar canal — the laterally placed small pea-sized ruptures are not revealed and so about 12 per cent of the cases will have normal fluoroscopic studies. On surgical exploration less than 8 per cent will be negative for cartilage disease. Air visualization is not as sharp cut and obvious as oil defects and, because of this, is not the choice of the majority for outlining the lumbosacral canal. In spinal cord tumors or any spinal canal in which there is a blockage that cannot be explained on plain x-ray films of the spine, fluoroscopic oil studies are indicated. Pantopaque or lipiodol has its greatest usefulness in the accurate localization of lumbosacral tumors. In the compensation cases visualization of the spinal canal, regardless of the contrast medium, should be resorted to only if the organic symptoms outweigh the functional ones. A needle into these patients' lumbar sacs is likely to be adding "fuel to the flame." In the differential diagnostic group having such a high percentage of pathologic plain x-ray films, visualization of the low spinal canal is rarely indicated. The larger number of the fluoroscopic studies will be in the group of spinal cord tumor suspects.

In summarizing the four groups considered from a neurosurgical viewpoint, it can be said that the diagnosis of a ruptured intervertebral cartilage is easy. The results following removal are excellent. The diagnosis of lumbar sacral spinal cord tumors is not always easy and usually requires more thorough x-ray, spinal fluid and spinal canal visualization investigations than the "disc" cases. Since the highest

percentage of spinal cord tumors are of a benign character, good results follow their removal. The diagnosis of the compensation cases entails a tedious, protracted, detailed history, a painstaking neurologic examination and may require all manner of laboratory and x-ray investigations. Surgery is not indicated for these patients. In the miscellaneous diagnostic group a meticulous history may be more helpful than the neurologic examination. X-ray studies of the lumbosacral vertebrae, the bony pelvis, the hip joints and even the femurs, are more likely to help in establishing the correct diagnosis. In certain selected cases of malignancy a section of the spinothalamic tracts in the dorsal spinal cord may offer relief from the lumbar sciatic pain. Those cases due to vasomotor imbalances may be benefitted by removal of the lumbar sympathetic ganglia. For these cases there are vascular studies which establish the criteria for surgery.

TREATMENT OF MORPHINE ADDICTION

JOSEPH C. MASSEE, M.D.
Atlanta

My experience with the treatment of morphine addiction in the private practice of medicine is not large. What I have to say might be said by any general practitioner except that, beginning my study of drug addicts at the Federal Prison, Atlanta, I was able to make some observations concerning drug addiction in general, and the treatment of drug addiction, which have been of value. Some of these facts it is well for us to remember in the treatment of morphine addiction. First, there are certain peculiarities of the morphine addict which we need to keep in mind. Those of us who see them at Grady Hospital, Atlanta, are accustomed to seeing "bums" with tattoo marks on their arms into which they thrust the needle when taking the drugs subcutaneously, or black marks along the veins in the antecubital space into which they put the needles when taking them intravenously. We think they are the typical

drug addicts. As we get into private practice, we find a large number of people, particularly elderly women who have had operations, or who have so-called heart attacks or asthmatic attacks, who are addicted to morphine.

There is a belief among physicians generally that these people must have their morphine, that it would be unwise or unsafe to take the drug away from them. I think that this is not true, and that it is becoming more and more truly recognized that morphine may be taken away from any patient without impairing his health. The law stipulates that a doctor does not have to take morphine away from a patient, if in his opinion the patient is an aged or infirm addict to whom the withdrawal of morphine would be dangerous. Article 85 of the Harrison Narcotic Law, exemption 1, gives the doctor that leeway. He can prescribe morphine if he desires to do so, and if it is his opinion that he must.

Everyone recognizes the propriety of giving morphine to individuals suffering from incurable diseases in whom there is intractable pain. This may be done properly in the ordinary practice of medicine. It has been interesting though to observe that people with intractable pain and incurable diseases seldom live long enough to require doses of morphine as large as the average addict takes. Therefore, a certain dosage is considered within the normal practice of medicine, and the fact that a certain patient or addict takes a larger dose immediately brands him as an addict, rather than one taking drugs in the legitimate sense of the word.

Arbitrarily it might be stated that about 5 grains a day may be needed for the relief of pain. More than that may be simply catering to drug addiction. A bad thing about prescribing more is that even drug addicts often find that they can get along very well and support their habit on 5 grains a day. They can sell the additional amount which they get from the doctor for enough money to support their habit, which is a nice economic balance if they can strike it. If you prescribe 10 grains of morphine a day for your addict, he can sometimes sell the excess for a dollar a grain. This simply

spreads the evil at your expense.

We will assume that you have a patient whom you wish to treat for drug addiction. The cardinal principle now is that you cannot treat a patient for drug addiction in his home. He either wants to cooperate, or he doesn't. If he doesn't want to cooperate, he is not going to do it in the home, because you can't put any control on him. If you have him in a hospital or in an institution for this treatment, you have means of control. If he does not want to cooperate and you try to treat him in the home, his withdrawal symptoms are going to be sufficiently severe to interfere with his continued desire to cooperate. I have seen that occur with people who were willing to go to the hospital and thought that they were really going to cooperate. When their withdrawal symptoms became acute, they resort to some means of getting the drug, and you have failed unless you can take precaution to prevent that.

In prison we have a unique chance to observe patients from whom the drug is withdrawn, unique because in prison there is a psychologic setup that is not duplicated in a private sanatorium or hospital. When the patient realizes that he is not to get any more drug regardless of what happens to him, a good part of his struggle is over and he resigns himself. Therefore, no amount of tantrum and no amount of exhibition of any type of symptom will do any good, and we see surprisingly few.

The bona fide withdrawal symptoms from morphine consist of lacrimation, salivation, nausea, diarrhea, muscle twitching and muscle cramps, and various sensations of which the addict will complain. The addict wants his drug not because it makes him feel good, but because he suffers if he does not have it. Because of this fact, and because it is often difficult to get the drug, drug addicts will voluntarily take the cure in order to support their habit and remain relatively comfortable on a smaller dose than that to which they have been accustomed. They will even resort to "cold turkey," or the sudden and complete withdrawal of the drug without other treatment, because they know it is safe and they know it is a quick way of getting their need and

tolerance for the drug down so that they can get along on a grain or two a day instead of 5 to 10 grains a day.

In the study of 454 patients at the Federal Prison, Atlanta, who were admitted for drug addiction, or on Harrison law charges, we carefully observed the blood pressure, urinalysis, blood count, and all the general observations made on drug addicts or patients in general to see if there were any rude unhinging of their physical state, and found no evidence of it. None of these patients collapsed, none lost his mind; some tried to get the drug, but none succeeded, and none of them had any serious symptoms. That work has been substantiated in other hospitals, particularly at Philadelphia General Hospital. Exhaustive chemical analyses have been made on the blood to determine whether there is any physical component of drug addiction that is important, and there is not. Drug addiction is a psychic matter. Of course there are physical sequelae of drug addiction — constipation, hemorrhoids, impaired nutrition and definite mental changes—but you need have no fear that any person requires morphine for health or for life.

Having that thought thoroughly in mind, you put your patient in the hospital and you begin to treat him. There are a dozen different methods. The essence of all of them is to reduce the drug gradually and give a substitute to make the withdrawal symptoms less severe. It is legitimate, if you wish, to take a patient who says he has been taking 10 grains a day and reduce his dose the first day 50 per cent, the next day 50 per cent, etc. You can draw out that treatment for two or three weeks with the idea that you are not going to hurt your patient if you make the reduction gradual. We have found that it can be done completely in three days. We have the patient at work in three and a half to four days after admission to the Prison Hospital, and he has had no drugs. The routine there is to give him a saline purge and a sedative of the barbiturate group to relieve symptoms, and let him sweat it out. If he is nauseated, he will vomit, his nose will run, his eyes will run, and he will be a miserable spec-

tacle for a few hours, but then he will be all right, except that he will still want the drug. With your private patient, about thirty-six to forty-eight hours after you begin treatment, and they get no drug, they fire you and get another doctor. The result is that they get their drug, which is what they want. However, if you really get the cooperation of the patient and the family, you can carry them through that psychic readjustment, as well as physical readjustment, with perfect safety if you will use these fundamental principles. Give them a purge because morphine is re-excreted into the gastro-intestinal tract no matter in what form it is introduced into the body. Then give some other form of sedative. One I find valuable is paraldehyde. This can be given to the point of deep sedation and it will carry them over the acute withdrawal phase. If you want to be a little more conservative about it, there is no harm in reducing each dose of morphine 50 per cent until none is given. Hyoscine, atropine, or other things may be given to lessen the discomfort. It used to be fashionable to give strychnine or sparteine to support the heart, but the heart does not suffer.

A doctor once admitted to the Prison Hospital sent for me saying that he was having an acute heart attack and needed me at once. He stated that on the previous day, while on his way to the hospital, the deputy marshal in Kansas City had found it necessary to give him a grain of morphine intravenously to save his life. I replied, "If you will just get the idea now that you are not going to get any more morphine, you will get along all right."

"But," he objected, "I'll die!"

"All right," I said, "on the bed, the floor, or anywhere you choose. It is your privilege."

He asked, "Are you willing to take that responsibility?"

"That is not my responsibility," I replied. "I have nothing to say in the matter. It is a rule of this institution to which you have gained admission." In three days he was at work as a clerk in one of the prison jobs, and nothing more was heard from him about his heart.

So, if you have your patient where you

can control him, you need have no fear. The patient will not die. He may have a terrific emotional upheaval, and there the art of medicine will enter as you sedate him with other drugs, and sedate him with your reassurances and personality.

Why put them in the hospital? Why not just trust that the family and the patient will cooperate and treat them at home? To illustrate the need, consider one patient who was eager to be relieved of this habit which he realized was ruining him, his home life, and his contacts with friends. He had been told by other doctors that he had angina pectoris and that he had to have this drug to preserve life. Nevertheless, he agreed to go into the hospital and take treatment, and to give me all his drugs. He gave me several hundred tablets of morphine and started the treatment. About thirty-six hours later his family was greatly upset. They said that he had suffered intensely; that he was in a condition of collapse, and they did not think that it was safe to proceed. Whereupon we went in to examine the patient and found his respiratory rate was ten a minute; his pupils were constricted; his skin was flushed and moist; and he could hardly be aroused. So, we searched and found the other tablets of morphine under the bed sheets, and proceeded to let him recover from his overdose, and then explained to him that he must not do that again. The same thing happened a little while later, and we found the last of his morphine in a suitcase. After that, we were able to really put him on a program of withdrawal, in which he suffered a good bit, but he came through all right and he is a happy man today.

In another case, an elderly man had been given morphine by doctors who were ethical and thought they were relieving legitimate pain. Each time his symptoms increased, the dose of morphine was increased. When I was called in on the case, he was taking 28 grains of morphine a day and getting worse. We reduced the dose to 14 grains over-night with the use of 100 mg. of demoral. Soon, seven grains a day sufficed. Although he was 90 years of age, he had no collapse symptoms. He is doing very

well at the present time on demoral and six grains of morphine. That could be completely taken away if there were any need for it. Actually he suffers from senile dementia and it is just as well to use one sedative as another to control the symptoms.

How successful are you going to be in the treatment of drug addiction? How many patients that absolutely stop using the drug are going to return to the habit? The warden's figures at the Federal Prison, Atlanta, showed that 90 per cent of those men admitted for a sentence of one year returned to the use of morphine. Of those who were admitted for five years or more, only 17 per cent returned to prison. Whether that means that they were better cured, or that they just had not had time to get back in or not, I don't know. Many of the men who were discharged, but who came in for their second sentence while I was there, told me confidentially that either they had never stopped the drug while they were in prison, or they started taking it as quickly as they could get to town after discharge. Often a man would be met at the gate on his way out by friends with morphine. More private patients who really want a cure will be permanently cured, than those who are forcibly cured in prison.

We had one prisoner who died of an overdose of morphine in prison. You may be interested in hearing how, which brings up one other important point, that a drug addict having been taken off the drug for a period of time loses his tolerance. If he is taking 20 or 30 grains (some claim they take 60 grains a day) before going into prison, he can't start back on that dose when he gets out because he loses his tolerance and will have to begin with a small dose. This particular drug addict had a girl friend who finally succeeded in getting morphine to him some months after he had been imprisoned. In preparation she visited him in prison under the eyes of the prison guard, she staying on one side of the cage and he on the other. This was a precaution the prison authorities found necessary to take because sometimes a girl friend in kissing her boy friend would spit capsules

of morphine into his mouth. However, this girl stayed on one side of the cage and the man on the other. The next day the man was found on his bunk dying of drug poisoning, and even though he was treated vigorously he could not be saved.

It was learned later that the girl had very carefully substituted compressed slabs of morphine for gum in a fresh package of chewing gum. While visiting the man and under the surveillance of the guard, she asked the prisoner if he would like to have some fruit and candy. She obtained permission to send this, but it could be sent only from the store operated by the government, controlled by the government, and run by the chief clerk of the prison. She went to this store across the street from the prison and bought two packages of chewing gum, a dozen oranges, and a box of candy from the prison storekeeper. He put these things on the counter and turned to a far corner of the store for some bananas, whereupon she put down her morphine packed as chewing gum, and stuck the other chewing gum in the pocket of her coat and the storekeeper sent the man the morphine, of which he took an overdose.

There are many other ways of getting drugs into the prison. Every prisoner who is admitted is given a thorough examination, including a rectal examination, and even then the newcomers try to get in syringes and supplies of morphine that way, only to be detected. There was a great excitement once. It was about the time that Ford was getting ready to announce a new model automobile that had not yet appeared, and the man assigned to make these rectal examinations came to me in great excitement. He said he had found something in a man's rectum and he had pulled and the man had screamed. He pulled again; the man screamed but nothing came. He just didn't know what it was and he wanted me to take a look — perhaps it was the new Ford. When I made an examination in the hospital, I found a polyp of the rectum.

Another man died from drug poisoning while in jail. He was permitted to come to Atlanta under guard on the occasion of the death of a relative, and while in town at a

prearranged location he asked permission to go into the toilet of the hotel where he had been brought by his guard. He went into one booth. His colleague was in the other and stuck a finger stall filled with morphine under the partition. He swallowed it and went back to jail, but the string had not been securely tied around the stall. It opened in his stomach and he died of morphine poisoning.

It is most difficult to control the procuring of morphine. If prison officials who are skilled in its detection can fail to keep it out of the prison, you need not think that you can keep the patients at home from getting the drugs when they need them.

In regard to the insulin therapy in the morphine addict, I have had no experience. I should think that it would act on the psyche as it is supposed to act in other mental disorders.

A particularly dangerous derivative of morphine is diacetylmorphine, or heroin. Possibly the use of heroin is on the decrease, and particularly because we have all been warned that its use in cough medicines is pernicious. Heroin is a greater habit former than morphine and should not be used. In spite of the fact that you can still prescribe elixir terpene hydrate with heroin, it is not a wise thing to use.

The best contribution that I can give you to your practice of medicine is the thought that you may take morphine away from any patient; that you may do so safely; you may do so at once; but you may do so only when you can control the patient's environment. Many of these people want to quit but they don't want to suffer, and they are going to get relief if they can. Unfortunately, a large number return to the habit when forcibly withdrawn from it.

The annual scientific and clinical session for 1945 of the American Congress of Physical Medicine has been cancelled. This meeting was to have been held in New York City, September 5 to 8, 1945.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

UNIVERSITY OF GEORGIA SCHOOL OF MEDICINE PLANS LARGE MEDICAL CENTER

The University of Georgia School of Medicine has made wonderful strides forward since it was placed under control of the Board of Regents of the University System. Full-time clinical departments in four fields of medicine date back to 1922. In 1937 four additional full-time clinical departments were added, and in 1943 three others. The further addition of about one-half dozen chairs in other specialties will round out a clinical faculty commensurate with a modern medical center.

The pre-clinical departments have long been on an efficient basis and the present personnel of these departments is of high quality. Original investigation and research in both the pre-clinical and clinical departments in the past ten years has attracted nation-wide attention. Textbooks published by faculty members during these years have attracted additional attention to the school. Some of these books are Cleckley's "Mask of Sanity," Mettler's "Textbook of Neuro-Anatomy," Krafka's "Textbook of Histology" and "Textbook of Embryology," and Greenblatt's "Office Endocrinology." Research papers too numerous to list here have been published. Research grants have been made by foundations and pharmaceutical firms to aid in the research by members of the school's faculty.

In addition to textbooks and research publications, faculty members have contributed to the armamentarium of the physician in practice and to that of other research laboratories. The department of bacteriology has produced a vaccine for the detection of one of the venereal diseases. This vaccine is now marketed by a well known biologic supply firm in the East. The department of obstetrics and gynecology has contributed a pelvimeter for the x-ray measurement of the size of the pelvis of the expectant mother; a device for packing the womb after childbirth in order to prevent hemorrhage; a resuscitating device for infants which has been approved by the Council on Physical Medicine of the American Medical Association as well as other devices for the use of specialists in this field. The department of physiology has invented a device for measuring and recording by photographic means direct blood pressure readings. These latter devices have been manufactured by the mechanic of the department and sold to many of the departments in other medical schools.

Four years ago a 50 per cent increase in the capacity of the school was authorized by the Governor and the Board of Regents. The first year class now accommodates 76 students instead of 48 as was previously the case. The faculty personnel was increased in accordance with regulations of the medical accrediting agencies.

In order to develop an outstanding medical center the school faces some significant needs.

First of all there must be an increased allocation from the Board of Regents for the maintenance of the school. Next additional full-time clinical specialists must be added to complete the faculty which is required for a real medical center. The third need, which is possibly the most urgent of the three, is increasing the indigent and semi-indigent patients for clinical teaching material demanded by the larger third and fourth year classes.

During the 1945 session of the State Legislature an act was passed authorizing the Board of Regents to buy, lease, or construct a general state hospital on the medical school campus, and to conduct it for the benefit of the sick poor of the State. While no funds were appropriated for the construction of the hospital, it seems assured that the necessary funds will be provided shortly after the termination of the war. A legislative committee has inspected the medical school and recommended that a receiving hospital for mental patients be placed on the medical school campus. Many patients could be cured and sent home from such a psychiatric institute without the stigma of having been sent to an insane asylum. It has also been stated that the next state tuberculosis hospital will be placed on the medical school campus in cooperation with the full-time clinical departments of tuberculosis and thoracic surgery. The realization of the construction of these three hospitals would more than supply the necessary clinical material for the enlarged third and fourth year medical classes.

Paving the way for the new general state hospital was the appropriation obtained during the past three years for the hospitalization of indigent patients from the rural counties of Georgia. This appropriation, amounting to \$50,000 a year, provides treatment for a comparatively small number of patients, although the great need of treating such patients is so evident throughout the State. The state and county welfare departments are deeply interested in the expansion of the Medical State Aid Program and in its culmination in a general state hospital of 200 to 500 beds.

Following the war there will no doubt be a marked increase in interest in improved medical care and in better medical education. This will bring a great demand for a better distribution of medical care so that individuals in outlying communities may receive the attention they need. The University of Georgia School of Medicine is looking ahead to its full cooperation in the plan to provide more, better and properly distributed medical care to the people of our State, and solicits the support of all citizens in the development of an outstanding medical center on its campus. Post-graduate medical training is an important part of this program. It earnestly requests, therefore, the enthusiastic team-work of all state agencies in bringing about this ideal setup for an efficient health program in our commonwealth.

G. LOMBARD KELLY, M.D., *Dean.*

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

AUGUST, 1945

THE GEORGIA CANCER CONTROL PROGRAM

The Georgia State-aid Program for indigent cancer patients has been in operation more than seven years. Although a full evaluation of the program must await the cumulative experience of many years, a superficial appraisal of some of the results may be made at this time. For example, sufficient time has elapsed so that it is possible to examine the record of 5-year cures among patients who were treated during the first two years of the program. Some idea might also be gained as to whether patients are now reporting earlier in the course of the disease than did those of former years. If so, an increase in the percentage of cures might be expected in the future.

Provisional figures are now available with respect to 5-year cures among patients who reported to the clinics prior to 1940. Although the follow-up of these patients is still incomplete, it is not expected that the final results will differ greatly from the figures quoted here. For the more common types of lesions the approximate percentages of 5-year cures are as follows: skin 80 per cent; lower lip 40 per cent; cervix 13 per cent; breast 15 per cent. For all other types of lesions taken collectively, the final figure will be less than 10 per cent.

In considering the figures given above it must be remembered that they represent the results obtained at the very beginning of the program. A large proportion of the patients who reported in those years had far advanced lesions. When this fact is taken into consideration the results are very gratifying. It is pertinent to inquire, however, as to whether these results may be expected to improve in the future.

If most patients could be induced to report for examination during the early stages of the disease, there is no doubt but that a sharp increase in the number of cures would follow. For example, in early breast cancer the cure rate could be expected to approach 70 per cent. In similar lesions of the cervix close to 80 per cent of cases could be cured. If these figures are compared with those obtained during the first two years of the cancer program, it is obvious that only a small percentage of the state-aid patients reported with early lesions.

Education of the laity with respect to the nature and early symptoms of cancer is a basic part of the cancer control program. These activities are carried on with a view to inducing

patients to report for examination during the early stages of the disease. How well the educational program is succeeding in this respect may not be known for many years, but some indications of success are apparent at this time.

Cancers of the breast and cervix are classified into various groups depending upon the extent of the lesion at the time the patient reports to the clinic. For example, breast cancers are classified into one or another of three groups depending upon whether the lesion is strictly limited to the breast and is freely movable, etc., (group 1); whether there is some attachment to the skin, axillary metastases, etc., (group 2); or whether there is still further extension of the lesion with attachment to the skin and chest wall, confluent masses of axillary glands, distant metastases, etc., (group 3). In a somewhat similar manner cancers of the cervix are classified into one or another of four groups.

If the groupings for cancers of the breast and cervix observed during the early years of the program are compared with those for the later years, some indication should be apparent as to whether patients are now reporting earlier in the course of the disease. In the table below is shown the groupings for breast cancer for the period 1938-41 as compared with those for the years 1942-44. The results deal with percentages and the figures are adjusted to the nearest whole number.

**CLASSIFICATION OF BREAST CANCERS
AS TO EXTENT OF LESION**

WHITE PATIENTS		
Group	1938-41	1942-44
1	14 per cent	24 per cent
2	38 per cent	35 per cent
3	48 per cent	41 per cent
COLORED PATIENTS		
Group	1938-41	1942-44
1	10 per cent	9 per cent
2	38 per cent	41 per cent
3	52 per cent	50 per cent

Insofar as white patients are concerned, it appears that a larger proportion of them are now reporting early in the course of the disease than was observed at the beginning of the program. Even allowing for errors in classification, there appears to be an unmistakable trend in the right direction. With respect to colored patients, however, no improvement is apparent. The great majority of them are still reporting with advanced lesions.

In cancer of the cervix the trend is somewhat similar to that observed in breast cancer. Among white patients whose lesions were classified, the proportion of those reporting while the disease was still limited to the cervix or with but slight extension beyond (groups 1 and 2) increased from about one-third during the early years of

the program to about one-half during the latter years. Due to the number of lesions which were not classified and which probably represent advanced cases, it is believed that these proportions are considerably higher than those actually observed. As to the indicated trend toward earlier cases, however, there is no reason to believe that it does not reflect the actual experience of the clinics. With respect to colored patients little or no improvement was noted in the number of cases reporting with early lesions. In this respect the results are similar to those observed in breast cancer.

The trend toward earlier cases, as observed among white patients, indicates that the day educational program is proving effective. The improvement has not been especially marked but, considering the fact that these patients came largely from rural areas, the results are gratifying. In regard to colored patients, however, there is little room for encouragement. It is obvious that greater effort is needed to reach that group.

The final test of the program, of course, will be the number of cures obtained. This, however, will be directly related to the success or lack of success in getting patients to report early. With an increasing number of early cases reporting to the clinics, it may be confidently expected that the number of 5-year cures will increase in the future.

W. J. MURPHY, M.D., *Director*
Cancer Control Service
Georgia Department of Public Health.

MANY LIMB INFECTIONS CURED WITH PENICILLIN INJECTIONS

Successful treatment of serious limb infections by administration of penicillin directly into the arteries is reported in *The Journal of the American Medical Association* for July 14. Three New York physicians, S. Thomas Glasser, John Hermlin, Jr., and Boris Pollock, present what they believe to be the first series of cases in which penicillin was administered by the intra-arterial route.

"The excellent results obtained are noteworthy," the authors say. "These findings assume added importance at this time because 70 per cent of war casualties are associated with wounds in the extremities. An even higher percentage of traumatic lesions (wounds or injuries) of the extremities are observed in war industries. Since these injuries are frequently complicated by infection, a preliminary report on the utilization of penicillin by the arterial route would seem to be timely."

The main advantage of this method of administering penicillin lies in the fact that the drug injected directly into the artery, is carried by the main blood flow immediately towards the limb

and the infected tissues. Also, the arterial method results in a higher concentration of penicillin in the blood. A drug introduced by any other route, such as by mouth, local application, or injection into a vein or muscle, is diluted before it reaches the infected areas. On the other hand, the intra-arterial method involves the least amount of dilution of the drug, which means that the tissues supplied by the artery which was injected will receive a higher concentration of penicillin than by any other means.

Furthermore, the authors point out, in the presence of inflammation due to infection, fluids are passed through the capillaries—the minute blood vessels—much more easily, thus allowing for greater filtration of the drug, which is deposited in greater concentration at the site of the infection and consequently is released slowly to the general circulation. The fixation of the drug in the infected area is even more effective if a tourniquet (constricting bands) is applied above the point of injection for ten minutes.

The method was tried in 24 cases of severe types of infection, with emphasis placed on infection occurring in arms and legs as a complication of hardening of the arteries with or without diabetes. The results obtained were described as excellent. The doctors found that in the absence of pus formation or dead tissue a single injection usually is sufficient for definite improvement or cure. The relief of pain is striking, and many patients have definitely been saved from major amputation. Also in cases where amputation was necessary the stump could be sewed together successfully even in the presence of infection.

The authors state that their experience prompts them "to suggest the use of this method for war wounds. We believe that many lives and limbs could be saved by the utilization of the arterial route."

DDT STUDIED FOR OUTDOOR USE HERE

Extensive investigations are now being conducted to determine the benefits and possible hazards involved in the contemplated use of the insecticide DDT on a large scale outdoors as part of a plan to control insect-borne diseases.

In the Pacific Theater, DDT proved highly valuable in bringing insect-borne diseases under control. However DDT will not be employed indiscriminately in this country until more research work has been completed on the general biological effects of this insecticide.

Besides killing insects that carry diseases, DDT may kill other insects that are beneficial—and thus affect the balance of nature which is important to agriculture and wild life. In combat zones, where the health of the soldier was at stake, it was necessary to ignore these considerations but in the United States general outdoor applications will not be adopted until more is known about these biological effects.

WOMAN'S AUXILIARY

President—Mrs. W. T. Randolph, Winder.
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

: OFFICERS 1944-45

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.
 Corresponding Secretary—Mrs. Alex Russell, Winder.
 Treasurer—Mrs. Ralph Fowler, Marietta.
 Historian—Mrs. W. W. Puett, Norcross.
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.
 Press and Publicity—Mrs. Charles Daniel, College Park.

WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

MRS. DAVID W. THOMAS, *President*
Lock Haven, Pa.

It has been said, "Life is but a moment between two eternities." It seems but a moment, the passing of a day, yet time reveals this is the report of the twenty-third annual year of the Woman's Auxiliary to the American Medical Association.

This is the first time in the history of the organization that we have had to waive a House of Delegates meeting. Another history is being made, and history will acclaim the heroes of the battle. May we, as never before, have faith and courage to see us through these perplexing and troublesome days. My hope is that when you read this report, a permanent peace will prevail throughout the world.

Any summary of my year's activity must be brief. More important than the exact number of meetings attended is the undeniable fact that had it been within my power, I would have visited most of the state auxiliaries. Ten states and seven counties comprise the extent of your president's travel this year, but the fond memories which will abide through all the years will be my generous compensation. At all of the meetings and functions, I was accorded every respect and an abundant measure of hospitality.

The intensity of healthy enthusiasm encountered was ample indication that we as doctors' wives have something to offer, to explain, and we are justified in being a Woman's Auxiliary to the American Medical Association and to the state medical societies.

Our auxiliaries foster professional growth, give a wider outlook to their members, and increase individual efficiency. The social opportunities afforded give an opportunity to lift barriers of social reserve and make possible cooperative participation in progressive living.

During the past year, in a splendid spirit of cooperation, each one of you has endeavored to do her part. To have served in such a time with such a creditable group, has brought to me a sense of unusual privilege and has emphasized increasingly, day by day, the responsibilities of that service. Our organization performs most

useful functions. It combines the promotion, among its members, of sociability and good fellowship with many vital, charitable, and civic services to the area which it embraces.

In many respects this year has been very different from any one of past history. Our year's work has been almost co-equal with our nation's year of war. This has caused many changes in our auxiliaries. As our husbands and sons have enlisted in the service of their country, we have joined the Red Cross and entered other occupations in which to show our patriotism. We find the doctors at home taxed beyond their strength to meet the demands which war industry has made upon them. Yet amid these unusual conditions and the many extra demands, our auxiliaries have held steadily to their purpose, and the year is not barren of results.

As we review the success of our year, the great amount of work the states have accomplished, the unequalled heroism of this year and the unparalleled sacrifices for the wounded and suffering in the war-ridden countries, we realize that at no time in the history of the world has duty or the opportunity to serve the medical profession been more imperative than now. Due to the unrest all over the world today, I hardly dared hope for an increase in membership or the organization of new auxiliaries. I am happy to report nineteen new auxiliaries organized.

The first conference, created under the new constitution and by-laws, comprising the State Presidents, Presidents-elect, and the Chairmen of Standing Committees met in Chicago, November 16 and 17, 1944, with fifty-seven members present. It was ultimately a success from many angles and viewpoints. New ideas, opportunities and possibilities were presented, which were inspirational and of value in the interchange of ideas and the freedom of discussion pertinent to all problems.

As I write my report, the bombers are grounded, the bugles have sounded, and the European war has ended, but a complete victory is not ours until the war in the Pacific is won. Since the war began in the cellars of Munich and on the Manchurian plains, this is the first time spring has come with a tingle of hope. We feel something brighter far ahead, victory and peace. Beyond it and beyond the peace, a shining chance to make this a better and healthier world in which to live. Someone has said, "Nowadays the

ocean seems to be a large body of water surrounded by trouble." World War II has confronted us with public health problems which, as a nation, we have never been forced to meet before. As America fought for liberty, it was comforting to know that its soldiers and its people had all the defenses science could provide.

The medical departments of its Army, Navy and Air Corps are the best in the world, and the alertness of its Public Health Service insures against any attacks. And above all, the American Medical Association has a body of approximately 142,000 or more practicing physicians—men who have met extraordinarily high standards, banded together to cooperate in safeguarding the health of the population in general.

The woman's auxiliaries could make no finer contribution to their medical societies than to acquaint the public with the advance of medicine and health education; continue promotion and distribution of *Hygeia*; emphasize consideration of post-war problems of medical economics; participate in the recruitment of students for the United States Cadet Nurses Corps; assist in the re-establishment program for returning doctors and their wives; foster improvement in public relations between organized medicine and the laity; cooperate with other organizations in a juvenile delinquency program and assist the medical profession with the National Council on the Physical Fitness Program.

A letter always brings with it a peculiar sort of charm and fascination, perhaps because its secrets are hidden behind a seal, and spontaneously one responds with a thrill of anticipation. Letters have been answered as promptly as possible. It was an arduous task, but one most pleasant. It presents a varied and interesting side of the work and has been our means of conversation.

This is probably the most difficult part of my report: to adequately express my gratitude to the Advisory Council for the assurance of their counsel and advice, cooperation and encouragement on all occasions; to my "Official Family" for their loyalty, cooperation and measureless kindness, for they have made possible whatever success may have been attained this year. Surely no president has ever had a more agreeable and happy family.

To Miss Wolfe, our efficient executive secretary, I acknowledge with thanks her assistance and cooperation; to each individual auxiliary a word of thanks and gratitude for the effort put forth to make this year successful and happy; for the hospitality of your homes; for the grand meetings and programs; for your material aid, one and all, I thank you.

A special word of appreciation is due to the Revisions Committee for rewriting our constitution and by-laws. This committee worked hours, days and weeks, for much had to be rewritten, every word weighed, and every meaning made clear.

Now I have reached the end of the trail. The twenty-third page in the book of our National Auxiliary has been recorded. Let us work together to make the coming year a brighter and happier year for the Auxiliary and the medical profession. Our salvation lies in the joined hand, the fused spirit, the consecrated heart.

"Little by little the time goes by; short if we sing through, long if we sigh; and little by little, an hour, a day, and another year has passed away."

BASAL TEMPERATURE RECORDS TO AID INFERTILITY TREATMENT

A basal temperature record to aid in determining the probable time of ovulation in individual women is being made available by the Medical Committee of the Planned Parenthood Federation of America to physicians interested in the treatment of infertility and the planning of conception.

As reported by Dr. Pendleton Tompkins in the issue of March 11, 1944, of the *Journal of the American Medical Association*, (Vol. 124: 697-700), it has been found that an accurate daily record of basal temperature is valuable in estimating the optimum time for conception.

There is a slight rhythm of variation in the normal temperature of a healthy woman—the temperature being lower during the first half of the menstrual cycle than during the later half. The transition from the lower level to the higher one occurs at about the time of ovulation. In many cases the temperature will show a sharp drop and then shoot immediately to the higher level which can be taken as an indication that ovulation is taking place. As the variation for the entire cycle may be less than half a degree, the patient must be provided with complete instructions and forms with which to plot her temperature accurately. The temperature is taken rectally each morning immediately upon awaking before the patient has gotten out of bed, talked, eaten, drunk or smoked.

The charts, as provided by the Planned Parenthood Federation, provide for a six month's record. They indicate the calendar months, the length of the individual cycle and the number of days backward from the onset of the menses at which ovulation can be estimated to occur.

The charts, together with the instruction forms for patient use, are available at cost through the Medical Department, Planned Parenthood Federation of America, Inc., 501 Madison Avenue, New York 22, N. Y.

WHAT OF THE FUTURE?

Before the war, Osler had been one of the great apostles of internationalism, of peace and comity among the nations. When the test came, his service to his country was man-sized and, in the great struggle, he lost his only son. Had he lived to play his part in the great work of reconstruction and reorganization, we may feel sure that he would have insisted that its success will depend upon the attitude of the old toward the young, that the society of the future belongs to the children of the future.—*F.H.G., A Physician's Anthology of English and American Poetry*, p. 19.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACKson 7979.

GEORGIA'S HOSPITAL - HOME COORDINATED PROGRAM FOR THE CARE OF PREMATURE BABIES

MRS. BESSIE F. SWAN, *Associate Director*,
Division of Public Health Nursing,
Georgia Department of Public Health
Atlanta

By his precipitant entrance into a world he is not fully prepared to meet, the premature infant creates a special care problem for both hospital and home. The preservation of his life is a challenge to medical and nursing skill.

It is of paramount importance that the specialized care provided in the hospital be carried on in the home if all the efforts of physicians and nurses are not to be in vain. For example, the supervisor of nurses in a Georgia hospital recently told of a premature baby who weighed only 2½ pounds at birth, and was for weeks the object of painstaking care and special nursing. Finally the baby's weight reached 6½ pounds and he was sent home. Several weeks later he was returned to the hospital with his weight again down to approximately 2½ pounds. The mother had received no help or instruction in the home and was unable to make the necessary adjustment in the care of her baby.

A hospital-home plan of care designed to make the transition period between hospital and home care as painless for the baby and family as possible would do much to prevent the return of premature babies to the hospital. What does this coordinated hospital-home program for the care of premature babies consist of? In brief, it is a plan wherein the hospital refers its premature babies to the local health department in order that the health agency may assist the family in learning to care for the child. It functions as follows:

1. The hospital reports the premature birth to the local health department and furnishes essential data as to the baby's condition and care.

2. The health department assists the family with the care of the baby when it leaves the hospital and, when indicated, visits the home prior



to the dismissal of the baby. Public health nurses frequently obtain an incubator and assist in getting the baby to or from the hospital, in a condition which is conducive to its continuous progress.

3. The health department reports back to the hospital on the home* situation and, at periodic intervals, on the general progress of the baby.

In reporting the case the hospital includes such information as the length of time the baby has been in the hospital, what has been done for it, and specific medical orders for beginning home care. Referral of babies may be done in several ways, by telephone, by letter, or through use of a printed form. In rural areas in Georgia it is not uncommon for a public health nurse to stop at the local hospital and obtain necessary information about the care of a particular baby from the nurse in charge.

(Continued on page 170)

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

BIOLOGIC FALSE POSITIVE SEROLOGIC TESTS FOR SYPHILIS

ALBERT HEYMAN, M.D.

Clinic for Genitoinfectious Diseases,

Grady Hospital

Georgia Department of Public Health
Atlanta

In recent years there has been a tremendous interest in routine serologic testing for syphilis. Not only are tests required of food handlers in many communities, but pre-employment, pre-induction, pre-marital and pre-natal tests for syphilis have also become commonplace procedures. In Alabama there is now legislation requiring every adult in the state to have a serologic test for syphilis. Since most patients with syphilis have few if any symptoms, these routine blood tests are important syphilis control measures and of considerable value in syphilis case finding.

A major disadvantage of mass blood testing is the occurrence of false positive reactions. Because of these reactions, many patients have been stigmatized as syphilitic and treated unnecessarily. Although the treatment of syphilis is no longer dangerous with the use of penicillin, the stigma and psychologic trauma attached to the diagnosis of syphilis makes the detection of these false positive reactions of considerable importance to the physician.

In general, there are three types of false positive reactions:

1. Those caused by technical errors.
2. Those produced by spirochetal diseases other than syphilis.
3. Biologic false positive reactions.

The errors caused by technical procedures, such as mislabelling specimens, faulty reagents and performance, or clerical mistakes, will not concern us here. These errors can best be avoided by using a reliable laboratory, either the state laboratories or one approved by the State Health Department.

False positive tests for syphilis occur quite frequently in diseases caused by spirochetes other than *Treponema pallidum*. In yaws, for example, positive reactions occur in 100 per cent of the cases; while in pinta and bejel, the incidence of false positives is also extremely high. Since these infections are generally confined to tropical areas, they are of little importance in this country.

Biologic false positive reactions result from a great variety of acute infections and their recognition is of considerable importance to the physician. The exact mechanism of their production is not yet completely understood.

Recent studies of serum protein fractions have shown that the antibodies of syphilitic sera differ from those of false positive sera in certain chemical and immunologic respects.

The two diseases which have been known for a long time to produce false positive reactions are leprosy and malaria. The incidence of positive reactions in leprosy has varied from 40 to 70 per cent. In malaria, it has been demonstrated that 100 per cent of the cases will at one time or other show a positive test for syphilis. This feature of these two diseases is well known and offers little or no problem for the practitioner.

The false positive reactions caused by more common conditions, such as respiratory infections, mumps, vaccinia and infectious mononucleosis are of considerably more importance. Before describing these reactions in detail, a discussion of quantitative serologic tests for syphilis is necessary. Quantitative tests have been found to be of value in the detection of false positive reactions and should be employed whenever such reactions are suspected. In the quantitative technic, the serologic titre of the patient's serum is determined on the same basis as the Widal or other agglutination tests. The patient's syphilitic titre is the highest dilution of the serum which gives a positive reaction, but the result is designated in units rather than maximal dilution. For instance, if a serum is positive in a 1:50, but negative in a 1:60 dilution, it is considered positive with 50 units.* Quantitative tests are not to be confused with the old method of reporting serologic reactions as 2+, 3+, 4+. This latter procedure has, fortunately, been abandoned since it was not a true measure of serum reactivity, although it was often construed as such.

We have also found that the use of several serologic tests simultaneously are of value in the detection of false positive reactions. As shown in the following cases, conflicting results are often evidence of false positive phenomena.

Infectious Mononucleosis: The occurrence of positive tests in infectious mononucleosis is of particular interest because of the frequent similarity of this disease to secondary syphilis. These patients may show generalized glandular enlargement, sore throat, headache and perhaps even a rash. When they also give a positive serologic test for syphilis, as 15 to 20 per cent of them do, the diagnosis of syphilis comes first to mind. The following case illustrates this problem:

*In the Kahn test, the quantitative titre is obtained by multiplying the maximal dilution giving a positive reaction by four. A quantitative titre below 4 units is recorded when the serum shows partial flocculation in the undiluted state and is negative when diluted.

M.C., a 31-year-old white seamstress, was referred to us because of a sore throat, headache, and rash of one week's duration. Examination revealed slight fever, a generalized macular eruption and a reddened pharynx. The patient denied sexual exposure and became resentful at our suggestion that she might have syphilis. Serologic studies revealed the following:

Date	Test for Syphilis	Quantitative Titre	Heterophile Antibody Test
12/16/44	Kahn positive		Positive 1:320
1/5/45	Kahn positive	3 Kahn units	
1/12/45	Kahn positive Wassermann negative	4 Kahn units	Positive 1:160
1/22/45	Kahn negative Wassermann negative		Positive 1:40

The patient's Kahn reaction finally became negative on repeated tests. It is easily understood how this case might have been mistaken for secondary syphilis and treated unnecessarily. The false positive reactions in infectious mononucleosis usually occur in the second week of the illness. They become negative in two weeks, but may occasionally persist for two to three months.

Vaccination: The discovery in 1940 that smallpox vaccination produced false positive tests for syphilis was of considerable importance because of the mass immunization of military personnel. Recently 16 to 45 per cent of the patients with "primary take" vaccinations were found to have false positive reactions. This reaction occurs 8 to 14 days following immunization and may last for as long as a month.

L.S., a 11-year-old child, was first seen on the pediatric service because of abdominal pain of undetermined cause. He recovered without therapy and was referred to us because a routine test for syphilis was returned positive. The patient at that time had no symptoms and no abnormalities were found on physical examination. He admitted, however, having been vaccinated for smallpox two weeks previously. The results of the serologic tests were:

Date	Test for Syphilis	Quantitative Titre
8/3/44	Kahn positive	
8/6/44	Kahn positive	
8/11/44	Kahn positive Wassermann doubtful	20 Kahn Units
8/17/44	Kahn positive Wassermann doubtful Hinton negative Mazzini doubtful	2 Kahn Units
9/1/44	Kahn negative	

In this patient, the falling titre of the quantitative Kahn and the conflicting results of the other tests provided the clue to the correct diagnosis.

Mumps: Mumps has occasionally been noted to produce false positive tests. In the following case this reaction persisted for six months after an attack of parotitis.

V. McD., a 42-year-old multipara, 5 months pregnant,

was referred by the County Health Department because repeated prenatal serologic tests for syphilis were positive. The patient had five normal children and had had repeatedly negative serologic tests until one year ago. She was an intelligent woman who understood the problem, but steadfastly denied extramarital sexual contacts. Her husband's serologic tests were repeatedly negative. The patient admitted having had a severe attack of mumps three weeks before coming to the clinic. Physical examination revealed no evidence of syphilis. The serologic findings were:

Date	Test for Syphilis	Quantitative Titre
8/23/44	Kahn positive	
9/7/44	Kahn positive Wassermann negative	4 Kahn units
9/14/44	Kahn positive Wassermann negative	4 Kahn units
9/25/44	Kahn positive Wassermann negative	4 Kahn units
10/4/44	Kahn positive Wassermann negative	4 Kahn units
10/17/44	Kahn positive Wassermann negative	4 Kahn units
12/11/44	Delivered normal child	
12/22/44	Kahn doubtful	
12/27/44	Kahn negative	
5/22/45	Kahn negative Wassermann negative	

The patient was given no treatment during pregnancy and spontaneously developed a negative Kahn test after delivery. The baby's blood test was negative at birth and at the age of 6 months. The positive serologic tests in the above patient caused considerable concern in view of the patient's pregnancy. The persistently low Kahn titre and the conflicting results of the Kahn and Wassermann tests led us to believe that the patient had a false positive reaction.

Respiratory Infections: Atypical virus pneumonia, as well as influenza and bronchitis, have been shown to produce false positives in as much as 23 per cent of the cases.

R.H., a 32-year-old white male, was first seen because of a cold and pain in the ear of one week's duration. On examination, the patient was found to have a severe upper respiratory infection, bilateral otitis media and bronchitis. The symptoms were relieved with sulfathiazole and the patient was referred to us because the routine test for syphilis was positive. The patient denied all symptoms of syphilis and no physical evidence of this disease could be found. The results of the serologic tests for syphilis were:

Date	Test for Syphilis	Quantitative Titre
3/2/45	Kahn positive	
3/6/45	Kahn positive	3 Kahn units
3/15/45	Spinal Wassermann negative	
3/17/45	Kahn doubtful	
3/23/45	Kahn negative Wassermann negative	
5/4/45	Kahn negative Wassermann negative	

This patient was at first thought to have latent syphilis and a spinal fluid examination was done preparatory to treatment. The serologic reaction became negative on repeated tests and we believe that the patient exhibited a false positive reaction caused by his respiratory infection. Tests for infectious mononucleosis were negative in this case.

There are a great variety of other infectious diseases which are known to produce false positive tests for syphilis. Among these are measles, chickenpox, hepatitis, typhus fever, and tuberculosis. In fact, almost any febrile disease is a potential cause of this reaction.

Procedure for Detection of False Positive Reactions

Just how does one arrive at a correct diagnosis when a false positive serologic reaction is suspected?

1. *Search for a basis for a false positive reaction.* A careful history for intercurrent infections, vaccination or other immunization is important. Since a great many common infections are known to produce false positive tests, any febrile disease occurring within three weeks preceding the test may be suspected as a cause of a false positive reaction.

Take blood for heterophile antibody test for infectious mononucleosis, for this illness is more common than is generally thought and may manifest itself with only trivial clinical symptoms.

2. *Epidemiologic Study.* Serologic testing of parents, siblings, or marital partner is often necessary and may at times give information of considerable value.

3. *Repeat Tests.* Always recheck the serologic test, preferably in another laboratory. It is also advisable to have the serum tested with a variety of methods, for conflicting results are often evidence of false positive reactions.

4. *Perform Quantitative Tests.* Most false positive sera have weak reactions, whereas early syphilis has a high titre. Periodic quantitative tests will show a fall in titre if false positive, but will rise or remain stationary if patient has syphilis. Although only a few laboratories in the State are now doing quantitative tests, the technique is simple and can be performed by most serologists.

5. *Allow Period of Probation.* If none of these procedures can establish the diagnosis, it is best to withhold therapy for several months. Very few positive reactions last more than 6 months. If the patient contemplates marriage or becomes pregnant, treatment is indicated in all cases in which doubt exists.

Spinal fluid examinations usually have little positive value, but may be done when other methods fail.

The provocative test is mentioned only to state that it is of no value.

Although no one of these procedures alone may supply a definite answer, consideration of all of these factors may be necessary. In reality,

the crux of the entire problem lies in the simple awareness of the occurrence of false positive reactions. We feel that the diagnosis of syphilis is of such importance to the patient from a social and psychological standpoint that every effort should be made to verify or disprove the diagnosis in every instance.

NEWS ITEMS

The Bibb County Medical Society dinner meeting was held at the New Yorker Cafe, Macon, July 3. Program: "Rheumatic Fever and Its Complications," Commander B. E. Goodrich, Chief of Medicine, U. S. Naval Hospital Dublin.

Dr. S. Ross Brown announces his release from the Navy and return to private practice, specializing in anesthesiology at 1000 Peachtree Battle Avenue, N.W., Atlanta.

Macon Hospital has contributed six interns to the armed services — five to the Army and one to the Navy. They were all graduated from the University of Georgia School of Medicine, Augusta, and are lieutenants: Dr. D. C. Sirmons, Dahlonga; Dr. T. L. Clary, Augusta; Dr. R. C. Montgomery, Jr., Butler; Dr. William E. Pound, Dr. Albert Fisher, Jr., and Dr. Marvin L. Davis, all of Macon.

Dr. Ben R. Thebaut announces the opening of offices suite 1101 Medical Arts Building, Atlanta. Practice limited to surgery.

Dr. H. F. Sharpley, Jr., president-elect of Chatham County-Savannah Health Council, Savannah, was named president, succeeding Dr. G. H. Lang, resigned, at a joint meeting of the trustees and general assembly. Dr. Lang's action was for personal reasons, the meeting was advised, his resignation being effective immediately. Dr. Lee Howard, chairman of the nominating committee, presented Dr. Sharpley's name, and Mrs. Carl Espy, council president, presided. Dr. Lang had held office since January, and members of the council complimented his valuable work.

Dr. A. D. Knott, Leesburg, a Lee County physician and surgeon, has been made Mitchell County health commissioner and has already assumed his duties, residing in Camilla. Dr. Knott's appointment was announced by Edward N. Hilliard, secretary of the Mitchell County Board of Health.

Captain William B. Armstrong, an Atlanta ear, nose, and throat specialist, who has been with the Emory Unit since 1942 and has served overseas nearly two years, is home on leave.

The staff at Milledgeville State Hospital, Milledgeville, has been increased to 21 with the appointment of five new physicians. Judge A. J. Hartley, state welfare director, said the additions were a part of the program to increase the staff to about 35 or 40 members. Judge Hartley recently announced that a \$200,000 hospital for the criminally insane had been approved and would be constructed at Milledgeville. The new members of the staff are: Dr. J. D. Combs, Muncie, Ind., graduate of the University of Georgia School of Medicine, Au-

gusta; Dr. L. E. Pennington, Madison, Wis., graduate of Emory University School of Medicine, Atlanta; Dr. Robert B. Quattlebaum, Savannah, graduate of the University of Georgia School of Medicine, Augusta; Dr. Jack B. Moon, Augusta, graduate of the University of Georgia School of Medicine, Augusta, and Dr. Veronica Murphy, Indianapolis, Ind., a graduate of the University of Iowa School of Medicine.

Dr. Abe J. Davis, Augusta, Richmond County health commissioner, recently attended a meeting of the Advisory Board of the State Board of Health, Atlanta.

Captain Thomas A. Futch, Jr., Thomasville, who has been in active army service since 1942 and has served in the India-Burma area since 1943, is home on leave.

Dr. Roy L. Johnson, Douglas, announces the removal of his offices to the offices formerly occupied by Dr. Dan A. Jardine before his entry into the Navy.

Dr. Sterling Claiborne, Atlanta, for three years a member of the Emory Unit in this country and abroad, is home for a short leave, as is Dr. Francis Parker, also a member of that unit.

AMERICAN REVIEW OF SOVIET MEDICINE

The third chapter of V. A. Negovski's scientific report "Agonal States and Clinical Death: Problems in Revival of Organisms" is published in the June issue of the *American Review of Soviet Medicine*. Experiments performed on 250 dogs by Professor Negovski reveal the importance of the length of time the dog is in a state of "clinical death." Professor Negovski states "the longer the duration of clinical death, the longer the interval before spontaneous respiration began and the ocular reflexes were re-established." This chapter contains the essence of the theory of revival of organisms with detailed illustrative material. In studying the heart action Professor Negovski states "The central vasomotor control is restored decidedly later than first cardiac contraction. The autonomic nature of the heart action at the onset of revival was shown by Petrov in 1937 who suggested that a slight increase in vascular tone preceded cardiac action. By analogy the first sigh of the newborn, according to Henderson, appears as a result of preceding development of general muscular tone."

The story of Valentin Cherepanov, the Red Army soldier who died and was subsequently revived by Professor Negovski substantiates the application of his experimental work on dogs.

"Venereal Disease in the Soviet Union" by J. A. Scott is reprinted from the British Journal of Venereal Diseases. Other articles in the journal are "Treatment of Peripheral Nerve Trauma" by M. L. Borovski, "Plant Insecticides" by P. A. Petrischova. A timely paper, "Anabesine Sulfate: A Protective Agent Against Bites of Malarial Mosquitoes" by V. A. Nabokov describes a new preparation for protection against mosquito bites. "The application of 5 per cent aqueous solution of anabesine sulfate" affords a safe protection against bites for ten hours." The *Anabasis aphylla* plant grows in abundance in the Soviet Union and its large scale production and application is possible.

OBITUARY

Dr. Charles M. Adams, aged 74, 23 West Paces Ferry Road, N.W., Atlanta, retired physician, died at the residence, July 3, 1945. He was graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1913. Dr. Adams practiced medicine in Buckhead from 1912 until he retired a year ago. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, Buckhead Fifty Club, Sardis Masonic Lodge No. 107, the Royal Arch Masons, Atlanta Commandery of Knights Templar, and the Brookhaven Methodist Church. Survivors include a son, Dr. Charles Clyde Adams, Atlanta; two sisters, Mrs. R. H. Pfannkuche, Gabbettville, and Mrs. Dixie Adams, and three grandchildren, Misses Ann, Alice and Alecia Adams, all of Atlanta. Funeral services were held at Spring Hill with Rev. T. Cecil Myers, Dr. William E. Craig and Dr. Nat G. Long officiating. Burial was in West View Cemetery.

Dr. Harry Ainsworth, aged 68, prominent Thomasville physician, died June 19, 1945. He was a native of Thomasville, son of the late Haywood Benjamin and Permelia Everett Ainsworth. Dr. Ainsworth was a graduate of the University of Maryland and College of Physicians and Surgeons, Baltimore, in 1901. He interned at the University of Maryland Hospital after which he came to Thomasville to enter the practice of medicine, to which he has devoted his lifetime in that city and section. He was first associated on the staff of the former City Hospital until its amalgamation with the John D. Archbold Memorial Hospital in which institution he has been a member of the staff from its opening day until his death. Dr. Ainsworth was a member of the Thomas County Medical Society, the Medical Association of Georgia, the Atlantic Coast Line Surgeon's Association, of which he was secretary for many years; the Georgia Mutual Hospitalization Association, and the Thomasville Methodist Church, where he served on the Board of Stewards and at one time was made chairman of that board. Surviving are his wife, the former Miss Marion Wiley Hayes; a son, Captain Harry Ainsworth of the U. S. Army Air Forces; a daughter, Mrs. Richard Crosby Glass, Miami, Fla.; one brother, Haywood Benjamin Ainsworth, Blakely; two nieces, and a nephew. Funeral services were held at the residence on North Broad Street with Rev. M. P. Webb officiating. Interment was in Laurel Hill Cemetery.

Dr. J. H. Campbell, aged 55, Commerce, died suddenly at his home April 14, 1945. He was born at Ila, the son of the late Mr. and Mrs. J. B. Campbell. He was graduated from Emory University School of Medicine, Atlanta, in 1916. Dr. Campbell first located at Jefferson as a general practitioner. He was a veteran of World War I and after returning from the services of his country, he took a course in bronchoscopy under Dr. C. Jackson, Philadelphia, Pa., and still later he took a special course in eye, ear, nose and throat at the Episcopal Hospital, Washington, D. C. He located at Athens, where he was a successful practitioner for many years. Six years ago he moved to Commerce. He

was a member of the Jackson-Barrow Counties Medical Society, the Medical Association of Georgia, the American College of Surgeons, and was by ability and personality an outstanding man in his profession. He is survived by his wife, the former Miss Ruth Stevens. Funeral services were held at the Presbyterian Church with Rev. H. Reid Newland and Rev. C. C. Tooke officiating.

Dr. Joel Toy Curry, aged 74, retired government physician and a resident of Macon, died at his summer home, Lakemont, June 30, 1945. Dr. Curry was a native of Baker County, was graduated from Mercer University, Macon, and the George Washington School of Medicine, Washington, D. C., in 1897. He was a member of the Bibb County Medical Society and the Medical Association of Georgia. Surviving are his wife, Mrs. Joel Toy Curry, Macon; two sisters, Mrs. Susan D. Hand, Pelham, and Mrs. W. N. Spence, Albany; and a brother, B. Curry.

RED CROSS ANNOUNCES CIVILIAN BLOOD DONOR RECRUITING PROGRAM

American Red Cross chapters throughout the nation will be permitted to recruit blood donors for civilians under a program announced by national chairman, Basil O'Connor. Under this project any Red Cross chapter may take part in the operation of a donor center for civilians sponsored by a recognized medical or health agency. The blood collected and the blood derivatives produced will be made available without cost to physicians, hospitals, clinics and patients.

This civilian program is entirely separate from the Blood Donor Service operated by the American Red Cross for the armed forces, Mr. O'Connor said, and chapters in the 11 metropolitan centers where the Red Cross is now recruiting donors for the Army and Navy will not participate in it. These are: Los Angeles, San Francisco, Oakland, Portland, Ore., San Diego, Chicago, New York, Brooklyn, Boston, Philadelphia, and Washington.

The formal announcement of the new program stated in part:

"The need for provision of blood and such derivatives as blood plasma and immune (measles) globulin in amounts sufficient to meet civilian needs is very real and great. Their unique and vital place in medical practice, so strongly emphasized by the war, is becoming widely recognized by medical and health agencies throughout the country, and many of these agencies already have developed or are planning programs to insure the provision of blood and its derivatives to meet civilian needs. The American Red Cross is now preparing to help its chapters to assist in this essential service."

Assistance in establishing standards and conducting a civilian program will be made available to chapters through the five Red Cross area offices. The new project will be supervised by an advisory committee of specialists to be appointed.

TYPHUS FEVER CONTROL

As part of its duties under the International Sanitary Conventions of 1944, the United Nations Relief and Rehabilitation Administration has now assumed leadership in the program for control of typhus in Yugoslavia.

The United States of America Typhus Commission formerly led the control program in Yugoslavia with UNRRA personnel assisting. The Commission signed an agreement with Marshall Tito last January setting up the necessary arrangements for the work. Mass inoculation of the entire population of Bosnia and Herzegovina is well under way and half a million people have been inoculated to halt the spread of endemic typhus in that area. DDT powder and vaccine were shipped to the area by plane so as to expedite the program.

Twenty UNRRA doctors, nurses, sanitary engineers and other technicians are now at work as members of the health staff of the UNRRA Yugoslav mission. The takeover of the control program by UNRRA was completed July first.

The first typhus epidemic of World War II in Yugoslavia was reported from the Partisan side in the winter of 1941-42. The disease reached a peak in the section then known as "Independent Croatia" the following winter when there were over 30,000 cases with more than 5,000 deaths among the civilian population in Western Bosnia and Dalmatia. In central and eastern Bosnia typhus reached epidemic proportions in 1944.

Typhus broke out in 1941 in a large concentration camp in Serbia where a number of gypsies were interned. It gradually spread over the country and in the winter of 1943-44 there was a severe epidemic.

With the arrival of the U. S. A. Typhus Commission last winter, modern methods of epidemic control were introduced. DDT insecticide powder is applied with hand or electric blow guns. Hundreds of people can be disinfected in a short space of time. No undressing, bathing, and subsequent disinfection of wearing apparel is necessary.

Dr. W. A. Sawyer, Director of the Health Division, expressed a hope that UNRRA, in carrying forward the work so well begun by the United States of America Typhus Commission, in cooperation with the health officers of the Yugoslav Government, would be able to rid Yugoslavia of louse-born typhus fever and so preclude the possibility of future outbreaks.

Typhus epidemics of this war can be traced to the last war. During the final stages of World War I and in the years of unrest and misery which followed, typhus cases ran into the millions in Eastern Europe and into the hundreds of thousands in the Balkans. Central and southern Europe and North Africa had their overgenerous share. During the twenty years interval of peace the incidence of typhus was greatly reduced. But the downward trend was interrupted by occasional flare-ups, and some typhus persisted in eastern and southeastern Europe. In general, had the war not broken out, the typhus-free area of Europe would probably have been gradually extended eastward and southeastward. But in wartime, the conditions of destitution under which people were forced to live—lack of soap, sanitation and housing facilities, and the refugee movements of people, all contributed to the breeding of lice which are carriers of the disease in areas already infected, as was the case in Yugoslavia. Hence, the spread of the disease and the threat of epidemic outbreaks menacing surrounding areas, is now being halted by all the modern methods of medical science.

GEORGIA'S HOSPITAL-HOME COORDINATED PROGRAM FOR THE CARE OF PREMATURE BABIES

(Continued from page 164)

The close cooperation of institutional and public health nurses is the cornerstone of a successful hospital-home coordinated program for care of premature babies. How may institutional and public health nurses get together to work out a plan of referral of these babies? They can have lunch together, get to know one another, be sociable. Arrange for conferences at a convenient hour to both groups of nurses. The particular system of referral is not as important as an earnest desire to enhance the care of premature babies. When this desire is given its rightful place and a system is agreed upon whereby hospitals report babies who need to be visited in the home and public health departments report on condition of babies and homes, it is up to both organizations to follow through with the plan. Occasional informal conferences between institutional and public health nurses are called for in this plan. The mutual motto should be "Keep Each Other Informed."

Prior to Georgia's coordinated hospital-home program, which is working out effectively in many areas, the hospital cared for the premature baby until time for its dismissal and then turned it over to the family. Occasionally the public health nurse visited the home through the invitation of the family or a kind neighbor but more frequently she neither knew of the baby's existence nor the weeks of hard work done by institutional nurses in an effort to get the baby in condition to be dismissed from the hospital.

Recently a visit was made by a public health nurse consultant and a local public health nurse to a Georgia hospital. The obstetric supervisor was asked if premature babies were referred to the health department prior to dismissal from the hospital. She smiled and said: "No, why should we refer them?"

It was then explained that the public health nurse would visit in the home and determine whether the situation was one which could be adjusted to the care of the baby when it was discharged, and report on home conditions and progress of the infant to the hospital. If necessary the public health nurse would help prepare the home and family for the care of the baby and would return on the day the baby was dismissed from the hospital, or as soon thereafter as possible, to help the mother. The supervisor at once saw the value of this service and needed no further convincing of the worth of a coordinated hospital-home plan for the premature baby. On this particular visit the local public health nurse and the obstetric supervisor formulated tentative plans for referring prematures and other selected babies to the health department for follow-up work.

While it does not matter who makes the first

move in the referral of babies for further care, it would seem more logical for the hospital nurse to take the initiative, as she has first knowledge of the birth of premature babies.

These are war days and time is valuable. Medical care is limited. Lives are at a premium. Let us plan and work together to save our premature babies. The country needs these potential men and women, and no work pays larger dividends in terms of personal satisfaction than the saving of a baby's life.

*A form for this purpose was recently developed by the City Health Department in Atlanta and a copy may be secured upon request.

NATIONWIDE TB SURVEYS SEEN AFTER VICTORY

Twenty-six outstanding x-ray equipment engineers — leaders in this little group which works side-by-side with the doctors, nurses and radiologists who lead the never-ending fight against tuberculosis — recently launched their newest offensive designed to hasten the day when large-scale mass chest examinations will become a reality.

First step in their newest contribution to this long-cherished dream of medical science will be an intensive course in electronic aspects of the photo-timer, an ingenious new device for insuring high-quality small film photographs of full-size x-ray images made at about one-sixteenth of the cost and in one-fourth the time required by earlier methods. Representing all parts of the United States and two sections of Canada, this group will receive their training at the Westinghouse X-Ray Division in Baltimore, Maryland, and will form the nucleus for similar classes in both countries.

Invented by Dr. Russell H. Morgan and Dr. Paul C. Hodges at the University of Chicago, the photo-timer was first manufactured late last year by Westinghouse.

Because of its absolute accuracy of reproduction the photo-timer makes possible mass chest surveys of a consistently superior quality not possible heretofore. Its miniature film records give specialists sufficient data to make dependable preliminary examinations, or "screenings" — indicating individuals who require no further attention and identifying those who require the more costly full-size picture for accurate diagnosis.

Although first used as a part of the small-film technic, the photo-timer now provides flawless control of large-size exposures as well.

"The photo-timer opens the way for practical large-scale mass chest examinations," A. P. Craig, manager of the Westinghouse X-Ray Division, pointed out, "but such an ambitious program requires doctors, nurses, technicians and equipment. Personnel, now available only in limited numbers because of the demands of war, will be available in adequate numbers after V-J Day. It is our task to see that the finest equipment is on hand to enable them to undertake this gigantic job.

"To meet this obligation we have completely redesigned our chest x-ray unit to take full advantage of the many opportunities afforded by the photo-timer. Now we undertake the equally important task of qualifying

personnel to see that this equipment is of maximum service."

The new small-picture technic was made possible by using a fast-lens, motor-driven camera to make a permanent record of the image cast upon the photo-fluorographic screen by penetration of x-rays through the body; and employing the timer's photoelectric cell to measure intensity of the image, and as an automatic switch to turn off current in the x-ray tube when ideal exposure conditions have been attained.

"Because the secret of all x-ray diagnosis is in the relative degree of light and shadow recorded as x-rays penetrate the body under investigation," Mr. Craig explained, "it is important that exposures be uniform in density and in what photographers call 'contrast'—the sharpness of distinction between light and dark areas.

"Before introduction of the photo-timer this factor depended upon judgment of the operator and, although many attained a high degree of skill in estimating the time required for exposures of persons of varying chest thicknesses, no human skill can compensate for internal conditions such as abnormal bone and tissue structures which effect penetration.

"Because the photo-timer measures the actual image intensity on the camera side of the fluorescent screen and because it also controls the x-ray tube, there can be no error and each exposure is of exactly the proper density for best diagnosis."

"Since automatic operation of the photo-timer makes it fast, and since small film makes it inexpensive," Mr. Craig continued, "miniature photofluorography, the small-picture technic—represents one of the art's greatest forward strides since discovery of x-rays by Wilhelm Konrad Roentgen in 1895. It points the way for large-scale mass chest examinations and it is only by such a thoroughgoing approach that we can hope to root out this disease which, despite the best efforts of a great band of unselfish men and women, still claims nearly 60,000 lives each year in the United States alone."

SCHERING CORPORATION APPOINTS NEW SALES AND PROMOTION HEAD

Schering Corporation, manufacturers of endocrine and pharmaceutical preparations, having offices in Bloomfield and plants in Bloomfield and Union, New Jersey, has appointed Dr. John N. McDonnell to the newly created post of Director of Domestic Sales and Promotion of that company, succeeding Mr. Arthur F. Peterson.

HEALTH OF TROOPS HERE IS EXCELLENT

During the past winter and spring the health of troops stationed in the United States has been excellent, surpassing that of any previous war year. The low hospital admission rate for all diseases reflects fewer communicable conditions, as it is during this period of the year that infectious diseases usually predominate.

There were less respiratory diseases than in any previous war year, although during May there was a slight rise in these cases. Pneumonia, measles, scarlet fever, meningitis, and rheumatic fever were all less prevalent than during the winter and spring of 1944. The only important infectious diseases of which this was not true were venereal diseases and infectious hepatitis.

Relapses in the United States of malaria infections acquired in tropical areas overseas increased each month until March, 1945, but have since declined slightly. With malaria control in all overseas areas now greatly improved, the number of relapse cases should continue to decrease.

The fact that most of our troops are well seasoned and there are fewer newly inducted troops is responsible in part for this improved health record. Most Army hospital beds here are now occupied by patients evacuated from overseas.

DENTAL OFFICERS RECEIVE RIGHT TO COMMAND

On June 30, a law was enacted by Congress which gives Dental Corps officers equal command privileges with other officers of the Medical Department except in the case of hospital commands. Hospital commands are delegated to Medical Corps officers according to Army Regulations.

Heretofore, command privileges of dental officers have been limited by law to within the Dental Corps.

When Dental Corps officers were first commissioned in 1911, they were commissioned only as first lieutenants while Medical Corps officers held higher ranks. The question of command was therefore not an issue. Now, however, the Dental Corps includes many high ranking officers. Furthermore, the Medical Department has expanded to include the Sanitary Corps, the Medical Administrative Corps, the Veterinary Corps and the Pharmacy Corps—none of which came under the obsolete law. The law had to remain in effect, however, until joint action was taken by both houses of Congress and approved by presidential signature.

Expert Clinical Interpretation of

Chest X-Ray Films

CHAMP H. HOLMES, M. D.

P. O. Box 365

Atlantic Beach, Florida

ANESTHETIST WANTED

Florida hospital, seventy-five bed capacity, fully approved. Full-time salary open, with full maintenance. Must be well qualified. Full information first letter.

Address, *The Journal of the Medical Association of Georgia*, Atlanta, Ga.



From where I sit by Joe Marsh

Dr. Walters Lends a Helping Hand

Dr. Walters got home early from a tough case the other day, and found his missus in the middle of house cleaning, with the furniture moved around, and the place a shambles.

Some men might have grumbled about coming home for a little rest and finding their homes upset. But not the doctor. He just took his coat off and pitched in and helped.

And when he got the last curtain back in place, and stepped down off the ladder, there was his missus with a tray of cold beer and cheese blintzes she'd made specially. And blintzes are the doctor's favorite dish.

From where I sit, it's little things like this that will help to ease our troubled lives today—see us through difficulties—keep alive the spirit of good fellowship and mutual respect. Try trading a helping hand for ice-cold beer and blintzes. See if it doesn't make life seem a little brighter!

Joe Marsh

COOK COUNTY Graduate School of Medicine

(In Affiliation with Cook County Hospital)
Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting August 13, August 27, and every two weeks during the year. One week Course Surgery of Colon and Rectum September 10. 20 Hour Course Surgical Anatomy October 8.

GYNECOLOGY—Two Weeks Intensive Course October 22. One Week Personal Course Vaginal Approach to Pelvic Surgery September 17.

OBSTETRICS—Two Weeks Intensive Course October 8.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

General, intensive and special courses in all branches of medicine, surgery and the specialties.

**TEACHING FACULTY—ATTENDING STAFF
OF COOK COUNTY HOSPITAL**

Address: Registrar, 427 South Honore Street,
Chicago 12, Illinois

A. J. Ayers, M.D.

X-Ray and Clinical Laboratories

Serological, Wassermann and Kahn Tests, Bacteriological Examinations, Autogenous Vaccines, Blood Chemistry, Basal Metabolism, Tissue Examination, gross and microscopic, Autopsy and Toxicological Examinations and Friedman's Test for Pregnancy. Well equipped X-Ray Laboratory, diagnostic and therapeutic. Containers and information furnished upon request. Reports telegraphed when desired.

111 MEDICAL ARTS BUILDING
PHONE JA. 3937
ATLANTA, GA.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, September, 1945

Number 9

MULTIPLE AND SOLITARY RENAL CYSTS

Clinical and Pathological Aspects

SAMUEL J. SINKOE, M.D.
Atlanta

Renal cysts have been classified as follows: (a) polycystic renal disease; (b) serous cysts, either unilocular or multilocular; (c) cysts of nephritis; (d) hemorrhagic cysts; (e) subcapsular calcified cysts; (f) dermoid cysts, and (g) hydatid cysts.

In view of their clinical interest, my remarks will be confined to discussion of polycystic renal disease and solitary renal cyst. These conditions occur infrequently. We are able to make a correct diagnosis of polycystic renal disease, but the diagnosis of solitary renal cyst is often confusing, and is verified only by an exploratory operation. True, polycystic disease is always bilateral, although the cystic changes in one kidney may be more advanced than in the opposite kidney, and are in different stages of development. These patients show hereditary and familial predispositions, and the condition can be transmitted through either sex. Numerous instances of polycystic renal disease in the same family have been reported. The fetal type of circulation is present in polycystic kidneys, corroborating the embryonic origin of this condition. These infants in whom the disease has been recognized frequently are victims of other congenital anomalies, e. g., harelip, spina bifida, and imperforate anus.

As to the origin and development of this condition, the theory usually accepted is that malfusion occurs between the collect-

ing tubules and the corresponding glomerular unit, thus providing the obstructive factor.

Pathology: A very striking and outstanding feature of this condition is the size and contour of the fully developed cystic kidneys. They may completely fill the lumbar region. The surface and parenchyma of the kidney contains numerous cysts which vary considerably in size. Many are thin and translucent. The renal capsule due to perinephritis is so adherent it is impossible to decapsulate the kidney without rupturing the cysts. They may communicate with one another and at times the cystic fluid may become purulent. Infection in the cysts may be followed by stone formation, and in some instances by purulent abscesses. Kidney destruction is due to pressure atrophy of the renal parenchyma as a result of the expansion of the cysts. Surrounding the cysts are areas of atrophic parenchyma and interstitial fibrosis. The glomeruli undergo hyaline changes due to thickening of the capillary basement membrane.

Symptoms: Due to the insidious onset, the majority of the patients with polycystic disease reach the age of 40 to 50 years before they experience definite symptoms, and the symptoms depend on the amount of kidney substance destroyed. If there is much destruction the condition may simulate a chronic glomerulonephritis, accompanied by hematuria, hypertension, and an abnormal increase of nitrogenous products in the blood stream. In addition, the patient may complain of headache, nausea and vomiting. These symptoms indicate a nephritic or uremic condition and mask the true nature of the existing pathologic process. The internist, to whom these patients are generally referred, should include a complete urologic examination in making a



Figure 1 (Case 1)

Bilateral pyelogram showing elongation of the renal calices, marked distention of one of the minor calices of the superior pole of the right kidney. The cups are well formed and there was no marked dilatation of the pelvis. Both kidneys showed a tendency to formation of a double renal pelvis.



Figure 2 (Case 2)

Bilateral pyelogram showing markedly elongated calices, with distention of the upper calix at the superior pole of the right kidney. Note the "spider-leg" deformity of both kidneys. In spite of severe renal damage the patient is able to engage in light work and lead a useful life following conservative therapy.

final diagnosis. Pressure symptoms, as a result of the encroachment of the cysts upon the adjacent abdominal organs, may be present. The presence of stones, tuberculosis, purulent infection, etc., may complicate the clinical picture. A perinephritic abscess may develop as a result of the spontaneous rupture of an infected cyst. A severe headache, the usual complaint of many of the patients, is generally due to atheromatous changes in the cerebral vessels, or to small aneurysms at the base of the brain and the occurrence of spontaneous subarachnoid hemorrhages.

Diagnosis: In true polycystic kidneys one or both kidneys may be palpable. As a general rule, they are large, firm, movable, and do not show signs of elasticity. Impaired renal function is always present and urinary findings are similar to those found in glomerulonephritis. These will show a polyuria, and a low specific gravity, albumin, pus cells, red blood cells, and occasionally casts. The presence of a hypertension, and abnormal blood chemistry findings, are diagnostic. The diagnosis is always verified by pyelography, and the

x-ray picture is very characteristic. The bizarre appearance of the pyelogram has suggested various names; e. g., spider pelvis or dragon pelvis. The major calices are elongated and spread out in various directions. The minor calices are usually not distorted, the cupping being clearly outlined. The cysts, due to their progressive enlargement, encroach upon the pelvis and calices, producing a crescent-shaped deformity, which is very characteristic.

Treatment: Since this condition is bilateral, and a considerable amount of the kidney substance has been destroyed, our choice of treatment naturally should be conservative. A good rule to follow is to employ the same treatment as you would in a case of chronic nephritis. Mild urinary antiseptics should be prescribed. Such measures as rest, avoidance of physical and mental stress, and the employment of a carefully regulated diet should be followed. Appropriate treatment should be prescribed if anemia is present or if the circulation is impaired. Occasionally, pyelitis or pyelonephritis may complicate the



Figure 3 (Case 2)
Intravenous pyelogram showing good renal function in spite of marked renal deformity due to encroachment of cysts. Note that the pyelographic medium is in the bladder 15 minutes following the injection of diodrast.

condition, and should receive proper therapeutic measures. Perinephritic abscess, following rupture of a cyst, should be incised and drained.

Extensive surgical procedures carry a high mortality, and should be delayed as long as possible. Operations on polycystic kidneys have been reported by numerous surgeons, in spite of the risk. These operations were performed principally for infected hydronephrosis, removal of calculi, incision of infected cysts and similar conditions.

SOLITARY CYSTS

Solitary cysts, which are classified as serous or hemorrhagic, result from obstruction to a group of secreting tubules, plus interference with their blood supply. They are not as rare as was formerly supposed, and are difficult to diagnose clinically. They are located just beneath the true capsule of the kidney and are separated from the pelvis by a thin wall. The wall of the cyst is adherent to the kidney substance and is shelled out with difficulty. They arise either from the upper or lower pole, and during their growth compress and destroy the kidney substance. The entire kidney may



Figure 4 (Case 3)
Bilateral pyelogram showing extreme elongation and distortion of the calices and renal pelvises, more marked on the left side. Both kidneys are ptosed (typical spider-leg deformity). A brown stag-horn calculus was present in the right renal pelvis. The large pyonephrotic area at the superior pole of the right kidney contained about 150 cc. of greenish-brown pus. Death resulted from progressive uremia.

be destroyed in this manner. There may be associated lesions in the same kidney; e. g., chronic nephritis, tumor, congenital anomalies, calculi, pyonephrosis, infarct, etc.

Symptoms and Diagnosis: The main symptoms produced by this condition result from pressure on adjacent organs. The urinary symptoms are negligible since they do not communicate with the renal pelvis. If there is sufficient destruction of the renal parenchyma, the renal function test on the affected side will be diminished. When they attain sufficient size, they may be palpable, particularly if the lower pole is involved.

The pyelogram is a valuable aid in our diagnosis, as it may show the actual outline of the cyst and the resulting filling defect produced by the encroachment of the cyst upon the renal pelvis.

Treatment: Nephrectomy is indicated if a major portion of the kidney is destroyed, and resection of the involved area if the cyst is localized. If the cyst is of the hemorrhagic variety, a nephrectomy is indicated



Figure 5 (Case 3)

Autopsy specimen of kidney (case 3) showing the numerous cystic areas and irregular outline of renal surface, following pressure of the cysts against the renal capsule.

since remnants of malignant tumor cells are frequently present.

REPORT OF CASES

Case 1—A white female, aged 35, married, was admitted to the urologic department of Grady Hospital, May 1938. She was conscious of a mass, accompanied by a dragging sensation, in the right side of her abdomen which had been present for twelve months. Additional symptoms were fatigue, loss of appetite, insomnia, nervousness and irregular profuse menstrual periods. She was poorly nourished, with pallor of her skin and mucous membranes. A palpable firm mass was present in the upper right quadrant of the abdomen, which moved on respiration. Her temperature was 100° F, pulse 80; blood pressure 125 systolic, and 74 diastolic. Examination of a catheterized specimen of urine showed a moderate trace of albumin, moderate number of pus cells, a few red blood cells and no casts. The Kahn blood test was negative. Cystoscopic examination revealed an obstruction in the upper third of right ureter. Both specimens contained numerous pus and red blood cells. The appearance time of the dye from the right kidney was eight minutes, and from the left kidney ten minutes. A flat plate disclosed marked enlargement of both kidneys, with marked ptosis of the right organ. Twenty-eight cubic centimeters of skiodan were slowly introduced into the right renal pelvis and 20 cc. into the left. The pyelographic interpretation was as follows: The renal calices of both kidneys were markedly elongated, presenting the spider-leg deformity, which is characteristic of polycystic renal disease. The right kidney showed a marked distention of the minor calix at its superior pole. The cups were well formed and there was some dilatation of the renal pelvis. Both kidneys showed a tendency toward bifurcation, and angulation of both ureters was present. Diagnosis: Polycystic renal disease.

Case 2—A white male, aged 51, consulted me Oct. 13, 1938. His symptoms, which were of four years duration, were characterized by severe headaches, vertigo, lumbar pain, poor appetite, fatigue, and frequency of urination. Examination disclosed pallor of his skin, but his mucous membranes were well injected. His temperature, pulse and blood pressure recordings were within normal limits.



Figure 6 (Case 3)

Section of polycystic kidney showing dilated tubules, granular degeneration and some fatty infiltration. There is moderate increase in fibrous tissue, with marked degeneration of the parenchyma.

The Kahn blood test was negative and his blood chemistry findings were not elevated. Palpation of his abdomen disclosed no masses, and there was no tenderness on deep pressure. A specimen of his urine showed a specific gravity of 1006, a heavy trace of albumin, and no sugar. Microscopic examination showed numerous pus cells, red blood cells and occasional hyaline and granular casts. A plain roentgenogram disclosed enlarged kidneys with no calculi. Cystoscopic examination showed no bladder disease and there was no prostatic intrusion. Both ureters were patent, admitting No. 6 catheters without difficulty. Specimens from both kidneys contained numerous pus and red blood cells. Indigo-carmin appeared approximately in four minutes from each kidney. A bilateral pyelogram was done and approximately 20 cc. of skiodan were introduced into each renal pelvis. A large amount of the contrast medium could have been introduced without causing discomfort. The pyelographic interpretation was as follows: Both kidneys showed extreme elongation of the calices (typical spider-leg deformity), and crescent-shaped appearance of the pelvis, accompanied by a filling defect. An intravenous pyelogram, which was performed later, showed normal excretion in spite of destruction of renal parenchyma. Diagnosis: Polycystic renal disease.

Case 3—A white female, aged 43, married, and the mother of two children, was admitted to the urologic clinic of Grady Hospital Sept. 21, 1939. Her chief complaint was excessive menstrual bleeding, which at one time required treatment with blood transfusion. This condition eventually cleared up following x-ray therapy. She also complained of abdominal distention, weakness, frequency of urination and gastro-intestinal upsets. She



Figure 7 (Case 4)

Pyelogram showing enormously enlarged polycystic kidneys. Several opaque areas in the left kidney apparently were calculi. The patient, a minister, is still able to attend to light duties in spite of kidney destruction and poor renal function.



Figure 8 (Case 5)

Pyelogram of polycystic kidneys, showing elongation of the major calices. The calices on the left side are distorted and the renal pelvis had a flattened, elongated appearance. On the right side the upper calix is elongated and distorted. Treatment consisted of a regulated diet and the administration of mild urinary antiseptics.

was emaciated. The temperature, pulse and respiration were normal. Examination revealed hypertension: systolic blood pressure of 172, diastolic 96. There was present a blowing systolic murmur at the apex which was transmitted to the axilla and over the precordium. Palpation of the abdomen revealed a nodular mass in the left side extending to the epigastrium, which moved on respiration. Another mass was palpable in the right lower quadrant. Examination of a specimen of urine showed a specific gravity of 1005, a heavy trace of albumin, and no sugar. Microscopic examination showed occasional pus cells and fifteen to twenty red blood cells to the field. The blood count was normal except for a reduction of red blood cells to 2,250,000, and the blood chemistry constituents were slightly elevated. A complete cystoscopic examination was performed and No. 6 catheters were passed into both pelves without difficulty. The right and left specimens of urine showed a moderate number of pus and red blood cells, respectively. The appearance time of the dye was ten minutes from the right kidney and six minutes from the left kidney. Quantitative estimation showed less than 5 per cent elimination. A pyelogram was made and approximately 60 cc. of skiodan were slowly introduced into each pelvis without discomfort. Examination of the x-ray films disclosed an extreme elongation and distortion of all the calices, with distortion of the renal pelvis. This was more marked on the left side. Examination of the pyelogram made in the erect position showed a marked ptosis of the kidneys. Following the examination she returned to her home, and for a time her general health was improved. However, after two weeks she returned to the hospital complaining of chills, fever, and severe headache. She became progressively worse, developed uremia and succumbed Oct. 24, 1939.

Necropsy showed both kidneys markedly enlarged, extending from the eighth rib anteriorly to the crest of the ilium on both sides. The left kidney was much larger than the right. The enormous enlargement of both kidneys was due to bilateral multiple, polycystic areas. In the superior pole of the right kidney there was a large pyonephrotic area containing about 150 cc. of purulent material. Many of the cysts contained purulent material. Within the minor calices connecting the pyonephrotic area, there was a brown staghorn calculus. Several sections of the kidney were studied and disclosed marked degeneration of the parenchyma. One section showed connective tissue containing an occasional dilated tubule, lined with low cuboidal epithelium; several large cysts were found with no cuboidal epithelium present, and contained albuminous material and desquamated epithelium. There were scattered areas of edema, and acute inflammatory cell infiltration. The glomeruli were hypertrophied and in some instances had undergone hyaline degeneration. Several tubules were dilated.

Case 4—A white male, aged 29, minister, was referred to Dr. Major Fowler of the urologic staff on Oct. 15, 1941. His chief complaint was severe left renal colic, which required opiates for relief. During 1939 he complained of a similar attack affecting the right side of the abdomen, for which he underwent an appendectomy. During January, 1940, he had a severe attack of pain in the upper right abdominal quadrant, with hematuria. The blood pressure was normal and repeated specimens



Figure 9 (Case 6)

Pyelogram of male patient, aged 45, admitted to the hospital in a coma. The diagnosis of polycystic kidneys was verified by clinical and urologic study. Following intravenous clisis and forced fluids, the patient improved. The pyelographic study showed that the renal shadows extended from the eleventh rib to the iliac crest. The calices were elongated and presented a bizarre appearance. A calcified process was present in the lower pole of the left kidney.

of urine showed albumin, red blood cells and a few pus cells. Because of the previous urologic history and persistent urinary symptoms, Dr. Fowler made a complete urologic study. An intravenous pyelogram showed enlarged kidneys, elongated calices and deformity of the renal pelvis. Chemical analysis of the blood showed N.P.N. 62, uric acid 4.7, and creatinine 4.5. Cystoscopic examination revealed that the right specimen contained an occasional blood cell and a trace of albumin. The left specimen contained many red blood cells, occasional pus cells and two plus albumin. The P.S.P. appearance time was eleven minutes, with good concentration, from the right; and twenty-two minutes, with poor concentration, from the left. X-ray study showed enormously enlarged kidneys. There were several opaque areas within the left kidney outline, apparently calculi. Retrograde pyelograms were typical of polycystic kidneys. A recent check-up revealed an increase in blood chemistry constituents and progressive enlargement of the calculi in the calices of the left kidney.

Case 5—A white female, aged 34, mother of eight children, was admitted to the urologic department May 1940. Her chief complaint was a dull pain and fullness in the left side of the abdomen, which had been present for two weeks. Additional symptoms were lumbar pain, nervousness, fatigue, headache and dizziness. She did not complain of any urinary symptoms. Physical examination revealed a well developed and well nourished female. The temperature, pulse, blood pressure, Kahn blood test and blood chemistry studies were all negative. Palpation of the abdomen disclosed palpable enlarged



Figure 10

Section of polycystic kidney showing extensive destruction of renal parenchyma, as a result of encroachment of cysts (from the anatomic department of Prof. H. Ferrari in Trieste).

right and left kidneys, which were freely movable. A moderate number of pus cells and occasional red blood cells were present in the urine. A cystoscopic examination was performed and No. 6 catheters were passed to each pelvis. The right specimen contained a few pus and red blood cells. The left specimen contained numerous red blood cells and a moderate number of pus cells. The appearance time of the dye was eight minutes from the right kidney, and four minutes from the left, with poor concentration. A bilateral pyelogram, in which 40 cc. of skiodan were introduced into the right pelvis and 20 cc. into the left pelvis, showed enlarged kidneys with elongation of the major calices. The calices on the left side were distorted, and the renal pelvis had an elongated, flattened appearance. On the right side the upper calices were elongated and distorted. The appearance of the pyelogram was indicative of polycystic renal disease. Treatment consisted of a regulated diet and the administration of mild urinary antiseptics.

Case 6—A white male, aged 45, was admitted to the urologic clinic, Sept. 15, 1942. His chief complaints were nausea and vomiting for several days, frequency of urination, nocturia, and cramping of the leg muscles. The patient was poorly developed, poorly nourished, and lethargic. His temperature and pulse were elevated, and he appeared to be acutely ill. Positive findings on physical examination were as follows: systolic murmur at apex, transmitted over precordium and to axilla; arteriosclerosis and hypertension, and the presence of a firm, movable mass in the right side of the abdomen. Examination of the urine showed a specific gravity of 1007, which was rather constant, a heavy trace of albumin, and no sugar. Microscopic examination disclosed a few



Figure 11 (Case 7)

Left pyelogram of a patient 73 years of age, with a large solitary renal cyst. The preoperative diagnosis was verified by an exploratory operation. The cyst, size of a grape fruit, contained over 100 cc. of straw-colored fluid. Recovery was uneventful. Note the medial and upward deflection of the proximal ureter and the renal pelvis. An intravenous pyelogram showed a normal right kidney.



Figure 12 (Case 7)

Roentgenogram of barium enema showing constriction of the descending colon, due to pressure of the adjacent mass. A sharply defined rounded mass extrinsic to the descending colon can be observed.

red blood cells, a moderate number of pus cells, and an occasional hyaline cast. An analysis of the blood was normal except for a red count of 3,000,000 and a white count of 11,000. The Kahn blood test was negative. His blood chemistry constituents were elevated and showed an average reading of N.P.N. 90 mg., urea 35 mg. X-ray studies of the gastro-intestinal tract disclosed no disease. A cystoscopic examination was performed and specimens were collected, which contained a moderate number of pus and red blood cells. The P.S.P. test showed no elimination from the right side in fifteen minutes, and eight minutes elimination time for the left side. Approximately 20 cc. of skiodan were introduced into each renal pelvis, without difficulty. The pyelogram was diagnostic of polycystic renal disease. The renal shadows extended from the eleventh rib to the iliac crest. The calices were elongated, and had a bizarre appearance; the renal pelvis was elongated also. A calcified process was present in the lower pole of the left kidney. Treatment was symptomatic and following forced fluids by mouth and intravenously the patient was dismissed from the hospital and referred to the outpatient department for further observation and treatment.

Case 7—A white male, aged 73, was examined by Dr. Spencer Kirkland and myself at the Grady Hospital, Oct. 18, 1941. His chief complaint was a slight pain in his left groin as a result of a left inguinal hernia, obstinate constipation of two years duration, and weakness. He was poorly nourished, but mentally alert. Examination of his abdomen disclosed a soft, smooth, freely movable mass in the left side of his abdomen, which measured approximately 8 x 6 cm. It was slightly tender on deep pressure and did not descend on inspiration. A

barium enema, followed by x-ray studies of the intestinal tract, revealed a sharply defined rounded mass, extrinsic to the descending colon. The colon was narrowed, apparently due to the pressure effect of the adjacent mass. The temperature was normal, and the urinalysis, blood count, blood chemistry studies, and blood Kahn test were all negative. A cystoscopic examination was performed and a No. 5 catheter was introduced into the left ureter after considerable difficulty. The collected specimen was normal, and the phthalein appearance time was three and a half minutes, with good concentration. It was impossible to catheterize the right ureter, and an intravenous pyelogram showed no right renal defects. The left pyelogram showed that the proximal ureter and the renal pelvis were deflected upward and medially. The renal pelvis and calices were normal in appearance. There was no line of demarcation between the lower pole of the left kidney and the soft tumor mass previously described and it was not known definitely whether or not the tumor mass was directly associated with the kidney. However, we felt reasonably sure we were dealing with left renal disease, and we did an exploratory operation through a left lumbar incision. A large cyst, the size of a grapefruit, containing over 100 cc. of straw colored fluid was encountered at the lower pole. Due to the fact that additional small retention cysts were present throughout the kidney, a nephrectomy was performed. The patient made an uneventful recovery. The specimen was examined and presented an irregular appearance, due to the presence of small cystic areas. Both the cortex and medulla were involved and a number of small cysts were scattered throughout the renal parenchyma. The pelvis showed no inflammatory changes. Microscopically, the glomeruli were found decreased in number and a few of them had undergone

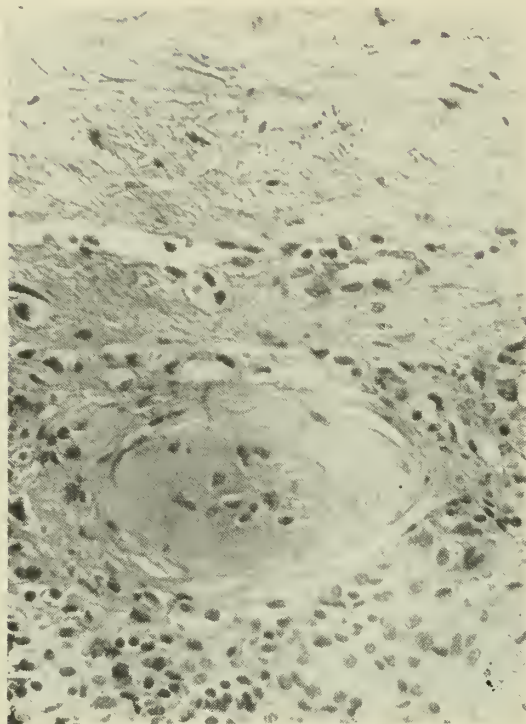


Figure 13 (Case 7)

Section shows marked fibrosis and moderate round cell infiltration. There is marked destruction of the normal kidney tissue. The glomeruli surrounded by areas of lymphocytic infiltration are decreased in number and a few have undergone hyaline degeneration.

hyaline degeneration. Surrounding the glomeruli were areas of lymphocytic infiltration. A section made through a cyst showed an incomplete lining, composed of hyalinized fibrous tissue. The surrounding tissue showed lymphocytic and neutrophilic infiltration with congestion of the blood vessels. The diagnosis was solitary renal cyst associated with small multiple retention cysts, and arteriosclerotic renal changes.

SUMMARY

Seven cases of cystic renal disease have been observed within a comparatively short time. The symptoms of polycystic renal disease suggest the presence of chronic glomerulonephritis. However, a complete urologic examination will confirm the true diagnosis. The urinary symptoms of solitary renal cyst are negligible, the main symptoms resulting from pressure on adjacent organs. The true diagnosis is generally made after an exploratory operation. It is interesting to note that the presence of cystic renal disease, in spite of destruction of renal parenchyma, did not interfere with the pregnancies of the female patients. One of the patients had eight normal pregnancies without any renal complications. Excessive menstrual bleeding was the predominant complaint of two of the patients.

The relationship that this bears to polycystic renal disease is problematical.

According to O'Crowley and Martland the persistent headache is a prominent symptom of this condition, and is generally associated with congenital cerebral aneurysms, and the occurrence of spontaneous subarachnoid hemorrhages.

Unless acute surgical emergencies arise, the treatment is mainly conservative. The restriction of proteins, avoidance of physical and mental strain, rest, and the employment of a proper dietetic regimen should be followed.

REFERENCES

1. Cabot, Hugh: Polycystic Kidneys, *New England J. Med.* 714-716 (Oct. 28) 1937.
2. Erickson, N. J.: Surgical Treatment of Polycystic Disease, *South. M. J.* 30: 524-527 (May) 1937.
3. Hepler, A. B.: Solitary Cysts of the Kidney, *Surg., Gynec. & Obst.* (Apr.) 1930.
4. Herman: *The Practice of Urology*, Philadelphia, W. B. Saunders Company, 1938, p. 209-218.
5. Lowsley and Kirwin: Polycystic Kidney, *Text Book on Urology*, Baltimore, Williams & Wilkins Company, 1926, p. 650.
6. Lower and Nichols: Roentgenographic Studies of the Urinary System, St. Louis, C. V. Mosby Company, 1933.
7. McKay, R. W.: Solitary Cysts of the Kidney, *South. M. J.* 25: 234-239 (Mar.) 1932.
8. O'Crowley, Martland and Harrison: The Association of Polycystic Disease of the Kidneys with Congenital Aneurysms of the Cerebral Arteries, *Amer. J. Surg.* (Jan.) 1939.
9. Reaves, J. U.: Polycystic Kidney Disease—Its Surgical Management, *South. Surgeon* 254-289 (Apr.) 1942.
10. Sinkoe, S. J.; Fowler, M. F., and Niceley, E. P.: Nephrotosis, Pyelographic Study, Clinical Features and Surgical Treatment, *M. J. Georgia* 31: 43-54 (Feb.) 1942.
11. Sinkoe, S. J.: Value of Pyelography in Urological Diagnosis, *Urol. & Cutan. Rev.* (Feb.) 1925.
12. Spencer, H. R.: Congenital Polycystic Diseases, *South. M. J.* 30: 524-527 (May) 1937.

OUR OSLER

What Osler meant to the medical profession in America, what he did for us, can never be adequately expressed. *Omne individuum ineffabile*. And his was an individuality so rare, so warm and radiant with goodwill toward his fellow creatures, that we shall scarcely look upon his like again. He was handsome, wise, witty, learned, courteous, fairminded and brave; with the poet whom he most resembled in happy disposition, he might have said:

To me Fate gave, whate'er she else denied,
A nature sloping to the sunny side.

—F.H.G., *A Physician's Anthology of English and American Poetry*, p. 7.

HASTEN THE DAY

We travelled in the print of olden wars,
Yet all the land was green,
And love we found, and peace,
Where fire and war had been.
They pass and smile, the children of the sword —
No more the sword they wield;
And O, how deep the corn
Along the battlefield!

—Robert Louis Stevenson, *A Physician's Anthology of English and American Poetry*, p. 193.

THE PRESIDENT'S PAGE

(This message by our President, Dr. Cleveland Thompson, was lost when the printer moved his place of business during the past month. Long, continued search brought finally results, and the message is now printed in full.

The President has been most kind in forgiving all of us at the offices of the Association, even though the message here published deals with "Dog Days," and perhaps dog bites.—Ed.)

DOG DAYS

Sirius, the Dog Star, has risen. All during August he may be seen keeping watch near Orion. The hottest month of the year is upon us, a cumulative heat, which by September has about broken the back of summer. Dogs are said to be more ferocious and dangerous during this hot period. Let one snap another in a questionable manner, or bite at a child, and off goes his head to the laboratory.

Doctors are not as discriminating about the time of the year they do their back-biting. Like Sir Benjamin Backbite in Sheridan's great drama, "The School for Scandal," some doctors' conversation with their patients is a perpetual libel on their fellow practitioners. Recently there has come to attention a threatened suit against an accomplished, honest doctor for malpractice, not because he had failed in the slightest scientifically or ethically to do a splendid job for his patient but because another doctor suggested that the difficult case might have been treated differently.

NEARLY ALL SUITS FOR MALPRACTICE ARE CAUSED BY SOME DOCTOR'S LOOSE CRITICISM OF A RESULT OF WHICH HE IS 100 PER CENT IGNORANT OF HOW IT CAME ABOUT. We know that professional calamities befall all of us at times: unexpected deaths, unsatisfactory results, complications over which no one can have control. The patient is apt to feel mistreated, given the suggestion by another doctor. The idea grows rapidly. Added to his disappointment over his not getting perfect results, he has a big bill to pay and his psychologic reaction is just right to make him feel that he has suffered criminal neglect.

The fact that there are so many "unknowns" in medicine that may make any of us trip on

occasion, should give us a great sympathy and understanding for a fellow doctor. As in all ethics, the "Golden Rule" should make us bite our tongues when we would make critical and destructive remarks to a patient about another doctor's work; certainly it is not constructively helpful to the patients, and their interest comes first always.

The time is growing near, thank the Lord, when the war will be over, but close upon that event financial normalcy will pinch many patients who have for several years enjoyed competent incomes. Having "upped" their standard of living, the readjustment will be difficult. Those who paid, during their affluence, big fees to doctors and who still have bad health, will be tempted to make complaint. So a marked increase of suits may be expected.

To be sure all malpractice cannot be hidden, nor should it be. But a physician is false to himself and to his colleagues if he doesn't get a full report on the case from the doctor who formerly had charge before he forms an opinion, much less expresses one.

A physician criticizes another to his patient for one of three reasons: jealousy and personal animosity; covetous greed, or insatiable ego. The reason matters little, the effect will be about the same. Lowell said of such ethics:

"In vain we call old notions fudge
And bend our conscience to our dealing;
The Ten Commandments will not budge,
And stealing will continue stealing."

We never profit by "highlighting" another's mistakes, and it little becomes the dignity and honor of our profession to slander a member of it to his patient. Dogs are not so underhanded, even when foaming at the mouth.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

SEPTEMBER, 1945

WAR ENDS WITH MANY PROBLEMS STILL FACING AMERICAN MEDICINE

"War's end finds many, many questions of vital interest to American medicine as yet unsettled," says the August 2 issue of *The Journal of the American Medical Association*. The *Journal* editorial follows:

"Suddenly the war ended. Men and women were mostly jubilant; some sorrowful; some even apathetic, with a feeling of exhaustion. The control over gasoline was removed; almost immediately roads were overwhelmed with traffic. Along the curbs stood motor cars with tires that burst or springs that cracked or engines that stuck—reminders that motoring will have to await a return to normalcy. So also with human beings—the stresses and strains of the war reveal themselves in a variety of inadequacies—combat neurosis was not limited to the military services.

"The end of the war in Europe brought to the headquarters of the American Medical Association a veritable deluge of letters from medical officers urging that steps be taken at once to insure their instant separation from the service. Occasionally a wife wrote saying 'You got my husband into this; now you get him out!' . . .

"The wounded are still coming home. For maximum recovery the armed forces carry the wounded to centers where they receive the attention of specialists. The Army Medical Department has already indicated that replacements for what the Army calls 'scarce specialists' are not available.

"War's end finds many, many questions of vital interest to American medicine as yet unsettled. The supply of medical and premedical students; the disposal of Army and Navy surplus medical supplies; a proper organization and system for medical services to veterans; the maintenance of intensified, coordinated research; the redistribution and relocation of returning medical officers; the provision of adequate numbers of residencies in the specialties; the development of medical care in the areas of occupation; the reestablishment of interchange of medical information throughout the world—these are but a few of the many problems that demand prompt consideration, careful planning, possible solution.

"Much proposed legislation affecting medical care in postwar America is already before the Congress. New measures tremble in the minds of Senators and Congressmen and in the thoughts

of personnel in governmental agencies who seek new fields to conquer. The Office of Defense Transportation relaxed to the extent of permitting groups of 150 individuals to attend conventions. Such relaxation does not, however, permit the assembling of the House of Delegates of the American Medical Association. Yet an early meeting of this body is desirable so that the policies of the Association regarding many problems may be established through its democratically selected official group.

"These are truly, even as in war, times that try men's souls. Scientifically minded physicians will realize that now, even as in war, haste must be made slowly. With sympathetic understanding, with the determination to see the job through to its fortunately happy ending, with the resolve to sink individual desires just a little more for the common good, let us practice more forbearance, so that our world may be that much sooner again a well ordered civilization."

THE SUPPLY OF PHYSICIANS

It is difficult to understand the public statements that a shortage of physicians is imminent in this country. During the abnormal war situation there are shortages in every phase of national life. However, the medical schools of the United States are now filled to about 110 per cent of capacity including the first year classes opening in the fall of 1945. On the accelerated program, they are training an average of about 6,800 graduates per year, twice the number of physicians who die annually. During the period 1942-48 about 10,000 doctors more than normal will have been graduated because of the accelerated, wartime program. Reliable actuarial studies by Selective Service Headquarters, and other authorities, indicate that the present production of physicians will insure one doctor to every 733 people in the United States in 1950, twice as many physicians per unit of population of any country in the world previous to the war and well above the ratio generally accepted as sufficient for good medical care. While the matter of distribution and the effective utilization of these physicians is a separate problem, the fact is that the number of doctors will be adequate to take care indefinitely of all of the civilian needs and the probable military and public health requirements, if the services of physicians are used to their full advantage.

Much has been said recently about the deferment of high school boys to enter pre-medical education rather than the military services. Selective Service Headquarters, the War Department, the Navy Department, the Interagency Deferment Committee, and the late President Roosevelt have all recommended against such a procedure in the light of the overall manpower needs of the country. Even if it were to be adopted, such immature, young students would not be

available for admission to medical schools with even minimum preparation until the fall of 1947. It is fully expected that by that time there will have been discharged large numbers of servicemen who desire and should be given the opportunity, if qualified, to pursue professional training. In addition, there are a certain number of men who are not acceptable for military duty for one reason or another and also many well prepared women students who desire to enter medical studies.

Some of the medical schools have eight or more applicants for each first year vacancy for the October 1945 class and expect at least that ratio for the fall of 1946. It is quite possible that during 1946 some of the medical schools may not have as many applicants as in normal times, but by 1947 there is every reason to suppose that the medical schools will have an adequate number of applicants as well qualified as war conditions have permitted.

The agitation recently to the effect that there will be a shortage of 35,000 doctors in the United States in the near future is at least disquieting, because any attempt to produce that number of extra physicians would require the creation of perhaps thirty new medical schools. Such a plan could only result in a serious lowering of the standards of medical education and medical services, which would be reflected for a generation. An over supply of doctors would lead to a deterioration of the standards and the ethics of medical practice. The present medical school facilities of the country are producing an adequate number of physicians and any attempt to dilute the proficiency and competence of the profession would be against the public interest.

These comments apply to the production of physicians and the recruitment of medical students and are not directed to the problems in other branches of science and the other professions. Medical education throughout the war has been preserved by the government almost completely intact, except for the shortened pre-medical college preparation and the abbreviated hospital experience, both of which were sacrifices for the war effort and which can readily be adjusted in the near future.

WILLIARD C. RAPPLEYE, M.D.,
Dean, Faculty of Medicine,
Columbia University, New York City.

PENICILLIN AND SULFADIAZINE VERY EFFECTIVE IN PNEUMONIA

Which is more effective in the treatment of pneumonia—penicillin or sulfadiazine?

Seven army doctors, reporting results of an extensive study in the August 25 issue of *The Journal of the American Medical Association*, said that the response from both agents was almost identical, the only difference being a more

abrupt fall in temperature and fewer instances of spreading infection with penicillin.

"It is not to be inferred, however," the doctors said, "that penicillin and sulfadiazine are therefore of equal value in the treatment of all cases of pneumonia, for such is not the case. The patients on whom the study was made were vigorous, healthy young adults of whom treatment was instituted early.

"The important conclusion to be drawn, then, is that since adequate doses of either drug will produce an equally satisfactory and, indeed, almost identical response, the lower cost and greater ease of administration may make sulfadiazine the drug of choice in this group of patients. Once the problems of cost and administration are overcome, however, penicillin will be favored because of its lack of toxicity and the probability that penicillin resistant strains of pneumococci will be encountered rarely if at all, whereas with the sulfonamides resistant strains occur in two to six per cent of the cases."

The doctors, who made the study at the Regional Station Hospital, Fort Bragg, N. C., are Lt. Col. J. Murray Kinsman, Lt. Col. Worth B. Daniels, Capt. Samuel Cohen, Capt. Joseph P. McCracken, Capt. Constance A. D'Alonzo, Lt. Samuel P. Martin and Lt. William M. M. Kirby, all of the Medical Corps, Army of the United States.

Use of the two drugs has helped to bring about one of the striking achievements of military medicine; namely, the reduction in the mortality rate of pneumonia from 28 per cent during World War I to approximately 0.7 per cent during the present war.

The effectiveness of penicillin and sulfadiazine in pneumonia treatment can be seen from the fact that of the 255 patients concerned with the study, there were no fatalities.

The doctors believe that patients seriously ill with the disease should be treated with penicillin because of its greater action against the pneumonia germ.

"From the dramatic results obtained in isolated cases," *The Journal* article said, "There is every reason to believe that the mortality rate of 6 to 10 per cent in civilian hospitals with the sulfonamides may be significantly reduced by penicillin."

In studies to determine the smallest amount of penicillin that could be used effectively in the treatment of pneumonia, the doctors found that 10,000 units injected into the muscle four times daily for three days produced cures in every instance, but with smaller doses there were relapses and failures to respond to treatment

Information received from the A. M. A., September 14, indicates the House of Delegates of that body will meet in Chicago December 3-6, 1945.

CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.
 Corresponding Secretary—Mrs. Alex Russell, Winder.
 Treasurer—Mrs. Ralph Fowler, Marietta.
 Historian—Mrs. W. W. Puett, Norcross.
 Parliamentarian—Mrs. Lee Howard, 625 East 41th St., Savannah.
 Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

As the Auxiliary members could not hear our president's report at a convention this year, we are quoting below the report as it appeared in *The Bulletin* of the Woman's Auxiliary to the American Medical Association. Mrs. W. T. Randolph's report is as follows:

"The Woman's Auxiliary to the Medical Association of Georgia has passed through the most trying year of its existence, as have other auxiliaries. It has been our aim to hold steadfast until peace is again ours and we may turn to the plans for increasing our activities that are a part of a serene and peaceful life.

Hygeia, Mrs. L. W. Williams, chairman: Subscriptions have increased over previous years. Hygeia was placed in USO centers, county and city school libraries, doctors' and dentists' offices and in health clinic waiting rooms. Richmond County received honorable mention in the national contest.

Legislation, Mrs. F. M. Martin, chairman: County chairmen have been informed on all matters of legislation, both national and state. Much interest was shown in a state child labor law. Warnings concerning the Wagner-Murray-Dingell bill, and other similar legislation, were sent out during the year.

Organization, Mrs. Lucius N. Todd, chairman: Very little effort was made to organize any new auxiliaries, but disbanded auxiliaries were contacted and attempts made to reorganize them. It was noted that much interest was shown in auxiliary work by the wives of younger doctors serving with the armed forces. Our total membership is 458.

Public Relations, Mrs. Harry Rogers, chairman: Securing speakers for civic groups, and PTA's and sponsoring radio health programs have been the outstanding projects of this committee. The auxiliaries participated in a social hygiene conference and a better citizens conference called by the governor, Hon. Ellis Arnall. The showing of health films has been a channel of good public relations. Active part has been taken in the cancer control program and one of our members is chairman of the state committee.

War Service, Mrs. R. V. Martin, chairman: The auxiliary has participated in the different phases of war service wholeheartedly. Special

emphasis was placed on the recruitment of nurses for the U. S. Cadet Nurse Corps. Many members have given thousands of hours to serving in blood donor centers. Red Cross work, the making of surgical dressings and as nurses' aides. They have also served in war stamp and bond booths.

Doctor's Day, Mrs. C. Almand, chairman: Unusual interest was manifested in this state project, and it is gratifying to see the wholehearted response of other states in adopting this idea. Messages were sent to doctors in service, and boutonnieres of red carnations were presented to doctors at home. Flowers were placed on the graves of our deceased doctors, among which was that of Dr. Crawford W. Long.

Student Loan Fund, Mrs. H. G. Banister, chairman: This fund, available to boys and girls who desire to study medicine but do not have the financial means, has helped in the education of many young men and women. It is one of the auxiliary's most serviceable projects.

FLUORESCENT LIGHT IS NOT HARMFUL

Does fluorescent light possess harmful qualities not found in other forms of artificial illumination? The Council on Industrial Health of the American Medical Association says "No."

Following an investigation by a joint committee on Industrial Ophthalmology, the Council, through its secretary, C. M. Peterson, M.D., reports in the *A. M. A. Journal* of August 25:

"Fluorescent lighting is not harmful to vision. It should not cause eyestrain if properly installed and used."

It was found that the light from fluorescent lamps resembles daylight more closely than from tungsten-filament lamps. "This color resemblance to daylight," the Council reports, "is a desirable quality," adding:

"Infra-red energy found in fluorescent lighting as now manufactured produces no known physiologic effect except that due to heating. Fluorescent light generates less heat per candlepower than tungsten lamps.

"Glare occurs in any system of lighting. . . . Excessive light may produce symptoms of eyestrain in susceptible individuals regardless of source. Constitutional factors should be corrected as well as the amount and kind of light."

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*FALSE POSITIVE REACTIONS
IN THE
SERODIAGNOSTIC TESTS FOR SYPHILIS

The specificity of the serologic tests for syphilis is of prime importance in the diagnosis of the disease. Unfortunately, these empirical tests are subject to general biologic influences which occasionally produce positive results in the absence of syphilis.

An extensive search of medical literature will reveal reports that practically all known diseases in man have been credited by some workers with inducing, in some instances, false positive reactions. Kolmer¹ suggests that many of these reports are probably the results of defective methods and errors in technic in laboratory test performance. Eagle² states that if the six diseases—trypanomiasis, relapsing fever, infectious mononucleosis, malaria, leprosy, and yaws—can be excluded, a persistently positive serologic test, even in the absence of history or clinical evidence, may be taken as *prima-facie* evidence of syphilitic infection.

Rein and Elsberg³, in a rather exhaustive study of nonspecific reactions with multiple serologic tests, add to the above list of diseases, vaccinia, filariasis, Weil's disease, typhus, upper respiratory infections and certain treponemal diseases. Barnes⁴ and associates recite instances in which positive reactions reverted to negative after an alteration in the patient's diet.

Thus, it is seen that all positive reactions encountered in the serologic tests are not of syphilitic origin. The sera of lower animals, and even some plant juices, have been found to be reactive to some of these tests.

Attempts have been made to devise procedures which will differentiate between specific and general biologic reactions. They have proved helpful in some instances but cannot as yet be considered conclusive in all cases.

The purpose of this paper is to call to the attention of the physicians the occurrence of nonspecific reactions in the serology of syphilis and to recite some instances of such occurrences in the laboratories of the State Department of Public Health.

Several years ago, in cooperation with Kitchen⁵, it was very definitely demonstrated that nonspecific reactions occur in malaria. This work has been corroborated by other investigators. Positive reactions have been found in some cases of infectious mononucleosis which reverted to negative upon recuperation of the patient.

While it has been observed, in an unpublished study, that specimens of blood submitted primarily for the tests for various fevers sometimes yield positive reactions in the serologic tests for syphilis, the lack of follow-up facilities has pre-

vented a definite exclusion of syphilis in these instances. It is felt, however, that some of these reactions were nonspecific and for this reason requests for the serologic tests for syphilis on specimens from febrile patients are discouraged.

Some few years ago a local physician called our attention to a positive reaction obtained on a specimen of blood collected in a routine manner on a few weeks' old infant, who presented no clinical evidence of syphilis. Some days later the blood of both father and mother was found to be negative. No antiluetic treatment was administered to the child and a subsequent examination of the blood was negative. It was then recalled by the physician that the first specimen of blood was collected a few days following smallpox vaccination.

This incident stimulated a study of the effects of smallpox vaccination on the serologic tests in a small group of selected children. The results of this study were inconclusive since, in the light of present day knowledge, the collection of the specimens was not properly timed. It appears now that positive serologic reactions are more likely to occur during primary and accelerated smallpox vaccine reactions.

With the establishment of Navy V-12 units in our colleges, it was a requirement that a serologic test for syphilis be included in the physical examination. Specimens of blood were collected from about 750 men at Emory University and from about an equal number at Georgia Tech within two or three days after the men reached the campus and before inoculations were administered. Only one positive and one doubtful serologic reactions were reported in these combined groups.

At Mercer University specimens of blood were collected from a much smaller group of 205 Navy V-12 men several days after they had been given smallpox vaccination. Ten (5 per cent) of these specimens gave positive or doubtful serologic reactions. No history or clinical evidence of syphilitic infection could be found in any of these men. The Kahn verification test gave general biologic or inconclusive type of reactions. Treatment was withheld pending subsequent serologic tests at one to two week intervals. The reactions declined in intensity, and at the end of two and one-half months the Kahn test had reverted to negative on all of these men and was confirmed by the Kline and Kolmer tests. These false positive serologic reactions most frequently occurred in men showing primary smallpox reactions.

In a recent survey in a high school five students were found to give positive or doubtful Kahn reactions. No history or clinical evidence of syphilis was found in any of these students. The serologic tests were repeated and the first

results confirmed. Four of these students gave a history of a severe cold, and the fifth had just recovered from an attack of influenza at the time the specimens were collected. About a month later the Kahn test reverted to negative and the Kline, Kolmer, Eagle, Hinton and Mazzini tests gave negative results.

In another patient the Kahn and Wassermann tests were found to be positive. Repeated tests were positive. The quantitative Kahn test gave 16 units. Specimens from the marital partner gave negative results. In view of a reasonable certainty of nonexposure and absence of clinical manifestations, the patient demurred against treatment for several months. The serologic tests were still positive at the end of that time. A well-known syphilologist was consulted. The positive serologic results were confirmed in his laboratory. No definite diagnosis was made and the patient decided against the mild suggestion of treatment. A few months later negative results were obtained by all the serologic tests. No explanation for the positive serologic tests over a period of several months can be given.

A physician called our attention to the case of a woman three months pregnant, who gave repeated positive Kahn reactions and in whom he could not find any supportive evidence. The Kahn verification test suggested a general biologic type of reaction. Treatment was withheld pending subsequent serologic tests at periodic intervals. A decline in intensity of reactions was noted and within about two months the tests were negative. Delivery was normal and the baby presented no signs of syphilitic infection. No reason can be given for the positive serology.

A young woman was employed in the office of a physician and some time later, in a routine physical examination, the blood showed a four plus Kahn reaction. Two repeated tests gave the same results. No history or clinical evidence could be found to support the laboratory results. Subsequent tests at monthly intervals was suggested. The reaction began to weaken and reverted to negative within about three months without treatment. Positive tests in this case remain unexplained.

The above are a few of many instances of similar nature which have come to our attention within the past few years. While the specificity of the routine serologic tests for syphilis is relatively high, they cannot be considered conclusive within themselves. For this reason the laboratory cannot take upon itself the burden of diagnosis. The clinician should regard the laboratory report as only one of the links in the chain of evidence before him.

There may come many instances where a positive serologic report is the only suggestion of syphilitic infection. A closer search into the history and a more thorough clinical examination may reveal supportive evidence in many cases.

There will be, however, some cases of a very puzzling nature in which the serologic test is positive and the history and clinical evidence are negative. In such instances it should be borne in mind that it is just as important to rule out syphilis as it is to rule it in. The patient should be questioned very closely relative to any illness, even of the slightest nature, within the past few months. Information may be secured which will suggest further study of the serologic reactions before deciding on treatment.

It is suggested that the physician communicate with the laboratory in such cases, giving history, previous serologic examinations, or any data that may be thought to be helpful. The laboratory then will advise relative to the quantity of a subsequent specimen desired and the time for its submission.

The laboratory has available all the recognized qualitative serologic procedures, the Kahn quantitative and verification tests. It cannot afford to employ them in a routine manner, however, and it is necessary to restrict their use to cases of a puzzling nature. For this reason, it is requested that the physician communicate with the laboratory before submitting the specimen.

The employment of these multiple tests has proved to be helpful in many cases, but sometimes it requires the submission of specimens at periodic intervals over a period of some few months. If some of the multiple tests are negative, and those which are positive show a decline in intensity of reaction, or if the quantitative test shows a drop in titer, it may be considered significant of a general biologic type of reaction. Persistent positive results, especially with a high titer, would suggest syphilitic infection.

E. L. WEBB, *Serologist.*

REFERENCES

1. Kolmer, John A.: *Serum Diagnosis by Complement-Fixation*, Lea and Febiger, Philadelphia, 1928.
2. Eagle, Harry: *The Laboratory Diagnosis of Syphilis*, C. V. Mosby Co., St. Louis, 1937.
3. Rein, Charles R., and Elsberg, Elizabeth S.: Studies on the Incidence and Nature of False Positive Serologic Reactions for Syphilis, *American Journal Clinical Pathology*, Vol. 14, No. 9, September, 1944.
4. Barnes, Milford E.; Borts, Irving H.; Miller, Chester I., and Spanswick, M. Pearl: *Journal Iowa State Medical Society*, November, 1943.
5. Kitchen, S. F.; Webb, E. L., and Kupper, W. H.: The Influence of Malarial Infections on the Wassermann and Kahn Reactions, *Journal American Medical Association*, April 15, 1939, Vol. 112.

NEW MEDICAL SERVICE CHIEF AT VALLEY FORGE

Lieutenant Colonel Steige D. Blackford, M.C., of Charlottesville, Va., brother of Dr. L. Minor Blackford, of Atlanta, is now Chief of the Medical Service at Valley Forge General Hospital, Phoenixville, Pa.

Colonel Blackford recently returned to this country after 30 months' service as Chief of the Medical Service of the 8th Evacuation Hospital in North Africa and Italy.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACKson 7979.

BETTER HEALTH IS NURSES GOAL

MRS. DURICE DICKERSON HANSON, R.N.
Executive Secretary, G. S. N. A.
Atlanta

Better health for Georgia through more adequate distribution of nursing facilities is the objective of a recently organized State Nursing Planning Committee and the State Nurses' Association.

Guided by directives of the Advisory Council to the Board of Health and Georgia Citizens' Council, this committee of seventeen representatives from civic and professional organizations, with possibly additional members, is framing a program that will first determine how nurses and nursing service can better adjust to and assist with the expanded program of health and education in Georgia.

The House Resolution No. 113-606b set forth Georgia's needs and authorized the creation of an Advisory Council to the Board of Health. The Georgia State Nurses' Association is represented on this council and the State Nursing Planning Committee will take into careful consideration all recommendations coming from the Council.

A recent report from the State Health Department shows that 5,007 more hospital beds are needed in Georgia in order to meet the minimum standards of three beds to every 1,000 persons. The standard of three beds per 1,000 persons is held to be minimum for general hospital care. Statistics show that patients are entering hospitals of all types in Georgia at the rate of 1.4 persons per second. The 386,439 admissions in 1944 were the largest in history and increased 32,759 over 1943. The census showed that the number of registered hospitals in the State decreased from 134 to 131 last year, although 3,180 beds were added to existing hospitals. This increase can probably be attributed to public appreciation of the importance of hospital care rather than to an increase in illness.

Health records show that 86 of the 159 counties in Georgia have no hospital beds. Of the

remaining 73 counties with hospital beds, 56 have less than the minimum of three per 1,000 population. Only one-third of the State's population is protected by sufficient hospital beds.

Distribution of Nursing Service

Nursing service is inadequately distributed in almost the same ratio to the inadequate distribution of Georgia hospital beds. In previous issues of this JOURNAL a description of the proposed Counseling and Placement Service promoted by G. S. N. A. was given. The counseling program would bring about a more adequate distribution of nursing service by improving standards of health and hospital service. Personnel practices, housing and living conditions for nurses should be considered and adjustments made.

Veterans' Administration Nurses

Salary increases, through reclassification of Veterans' Administration nurses, is expected to attract large numbers of well qualified nurses to this important and vital service. Nurses employed by the Veterans' Administration are classified by Civil Service on a full "professional" status beginning July 1, 1945. Salaries now will range from \$2.320 to \$5.180 base pay, plus overtime, with automatic administrative raises at regularly specified intervals of \$100 a year minimum.

Educational Programs

Educational programs are also being developed and will keep Veterans' Administration nurses up-to-date on the latest in medicines, treatments and nursing technic. A new policy of automatic rotation after a period of two years in an isolated Veterans' Administration hospital will prevent any feeling that nurses are being assigned indefinitely to any one remote facility.

If Georgia hospitals and health agencies are to expand their services, one of the first services to be considered is the nursing service. Educational and health programs are necessary to insure stability and safe nursing care.

The program of this new State Nursing Planning and Counseling Committee is most timely and the full cooperation and assistance in promotion is expected from all state nursing groups and civic organizations, as well as medical, health

and educational groups, if the critical civilian nursing service situation is to be remedied.

Annual Business Session of G. S. N. A.

The Georgia State Nurses' Association has made special application for permission to hold the annual business session during the early part of November 1945. Reorganization matters are to be considered. *The Bulletin* of the Association, entitled "Georgia Nursing," was mailed to the membership in August. *The Bulletin* published facts covering all phases of Georgia nursing and a tabulation of the distribution of nurses by district associations, general population and hospitals.

A. F. H. A. TO ACCREDIT SCHOOLS OF PUBLIC HEALTH

The Committee on Professional Education of the American Public Health Association, of which William P. Shepard, M.D., is chairman, is undertaking a program for the accreditation of schools of public health. The initiative for this urgent project came originally from the Association of Schools of Public Health, in a resolution adopted in April, recommending that the A. F. H. A. "create a properly constituted accrediting body to carry forward progressively a list of universities qualified with regard to program, personnel, and facilities, to offer adequate courses leading to the degrees of Master of Public Health, Doctor of Public Health, and the Diploma in Public Health." This was followed closely by a similar request to the Association from the Surgeon General's Committee on Postwar Training of the Public Health Service.

The Association now announces the inauguration of the project with funds made available through the generosity of the Commonwealth Fund, and with the appointment of Professor C. E. A. Winslow of New Haven, Connecticut, as the counselor in charge of the investigative work. He will be aided by persons experienced in the administration of health departments, chosen from various localities.

Accreditation will be based on a visit to the institution by a representative of the committee and other data. A copy of the report of the staff will be submitted to the administrative head of the institution before submission to the Committee on Professional Education, and the committee will provide a hearing to him or his representative if desired. Decisions of the committee will be finally subject to approval by the Executive Board of the Association. In certain cases, provisional accreditation may be granted, subject to the fulfillment of specified requirements within a stated time.

It is planned to concentrate first on the basic one year of training qualifying for the degree of Master of Public Health (in Canada, Diploma of Public Health). At the same time or subsequently, a list of institutions will be accredited for the more advanced degree of Doctor of Pub-

lic health, perhaps involving specialization in particular administrative or clinical fields.

At a later date the program will be extended to consider facilities for M. P. H. training adapted to particular specialties such as health education; to such general university degrees as the M.S. and the Ph.D., which are given without specific designation but with specialization in basic areas related to public health (such as bacteriology or statistics); to specialized degrees in engineering and other fields related to public health; and to administrative areas suitable for practical field training before or after the basic M. P. H. year.

The offices of the American Public Association are at 1790 Broadway, New York 19, N. Y. Reginald M. Atwater, M.D., is the executive secretary.

U. N. R. R. A. NEEDS HELP

The Chinese Government has requested UNRRA to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese.

General Surgeons
Orthopedic Surgeons
Genito-Urinary Surgeons
Gynecologists and Obstetricians
General Physicians
Dermatologists and Syphilologists
Ophthalmologists
Otolaryngologists
Radiologists
Dentists
Pediatricians
Laboratory Technicians
X-ray Technicians
Sanitary Engineers
Public Health Engineers
Public Health Nurses
Clinical Nurses

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physical condition.

Will those interested please write to UNRRA, 1344 Connecticut Avenue, N.W., Washington 25, D. C.?

FIRST MEDICAL OFFICER RELEASED ON POINT SYSTEM

The first medical officer to receive a discharge under the Army's point system is Major Wallace P. Ritchie, 40, of St. Paul Minnesota, who has amassed a total of 121 points.

Taken completely by surprise, Major Ritchie received papers from The Surgeon General's Office within a few hours after he had landed at Bolling Field in Washington from Italy directing him to proceed to the separation center at Ft. Sheridan, Illinois.

Serving overseas for 32 months, Major Ritchie wears three battle stars in his campaign ribbon. He joined the Army in February of 1942.

NEWS ITEMS

Emory University School of Medicine, Atlanta, announces changes in the medical faculty, following a meeting of the board of trustees. Dr. William Frank Friedewald, associated since 1943 with the International Health Division of the Rockefeller Foundation, was named professor of bacteriology and chairman of the department, succeeding Dr. Roy R. Kracke, who has become dean of the School of Medicine at the University of Alabama.

Dr. William C. Warren, Atlanta physician and formerly associate professor of clinical otolaryngology, was appointed professor of otology and rhinolaryngology and chairman of the department, to succeed Dr. Calhoun McDougall.

The committee also approved the appointment of Dr. R. Morris Paty as professor of surgery and acting head of the department of surgery. He will continue as associate dean of the School of Medicine.

Dr. Harry R. Lipton, now assistant in psychiatry, was appointed instructor in psychiatry, effective immediately. Other new appointments in the School of Medicine include Dr. Marion Hester as instructor in ophthalmology. He received his medical degree from Emory University, was resident at Grady Hospital, Atlanta, in eye, ear, nose and throat work from 1939 to 1942. He recently received his medical discharge from the Army. For the Nursing School Miss Foster Adair was appointed instructor in biochemistry for the classes in nursing. She graduated from Randolph Macon in 1943 and has been a research assistant and a graduate student in biochemistry at Emory University since 1944.

Dr. George H. Noble, formerly of Atlanta, announces he will locate at Monroe to practice medicine. He is the son of the late Dr. George H. Noble, Sr., Atlanta, and is an able and successful physician.

Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, Augusta, declared the \$200,000 appropriation on approval of the Board of Regents for operation of the medical unit falls short of the needs by \$25,000. Emphasizing that he is offering no criticism of the board, Dr. Kelly asserted that his statement is one of fact. "We need \$225,000 to render the service we should be giving the State," he said. Pointing out that \$50,000 of the sum appropriated must go for operation of the State Medical Aid Program, Dr. Kelly said that left for maintenance of the Medical School \$150,000, far short of the actual needs of that unit.

Dr. Edwin R. Watson has resigned his position as director of the Division of Maternal and Child Health with the Georgia Department of Public Health, to go into private practice in the city of Macon. Dr. Watson will specialize in pediatrics and will be associated with Dr. C. Hall Farmer, 553 Walnut Street, Macon. Dr. Guy C. Lunsford, director of local health organizations, will serve as acting director of the Maternal and Child Health Division.

Dr. J. C. Patterson of Cuthbert has been appointed to the State Board of Health by Governor Ellis Arnall, succeeding the late Mr. R. C. Ellis of Americus. Dr.

Patterson was recommended for the appointment by the Third District Medical Society.

Dr. Thomas M. Hall, Milledgeville, retired physician, who almost half a century practiced his profession in Baldwin County, celebrated his 74th birthday quietly at his home, July 16. Dr. Hall has a legion of friends throughout the county who extended congratulations and best wishes.

Dr. John T. Akin, Jr., Atlanta, announces the opening of his offices for the practice of surgery, suite 1111 Medical Arts Building, Atlanta. He is associated with Dr. Floyd W. McRae.

The Bibb County Medical Society dinner meeting was held at the New Yorker Cafe, Macon, August 7. Lt. Comdr. R. A. Boone was in charge of the program.

Dr. W. P. Smith of Bowdon has practiced medicine 54 years. He celebrated his 79th birthday July 9, but the anniversary date meant very little to this widely known and well beloved physician who went about the day at his daily task of helping others. His advice on how to keep healthy is to sleep and eat regularly.

Dr. J. Frank Harris, Atlanta, announces the opening of an office for the practice of internal medicine, suite 410 Medical Arts Building, Atlanta.

Dr. Eugene Rollin Corson, one of Savannah's best known citizens and physicians, celebrated, quietly at his home, his 90th birthday, July 20. Widely known as a roentgenologist, Dr. Corson has been noted for his research work in use of the x-ray. He was honored several years ago by the Georgia Medical Society with a dinner in recognition of his fine work. At this dinner he was called "the ideal physician."

The Fulton County Medical dinner meeting was held at the Academy of Medicine, Atlanta, August 2. Scientific program by staff members of Lawson General Hospital, Atlanta, as follows: "Case Report on Porphyria," Major Henry J. Lenhoff, Executive Officer of Medical Staff; "Eosinophilic Granuloma of Bone," Lt. Col. John M. Wellman, Chief of Surgical Service; "Boeck's Sarcoid," Lt. Col. Richard H. Wood, Chief of Medical Staff; Discussion: Lt. Col. John Hamilton and Lt. Col. Hans Smetana.

Dr. Richard M. Nelson, eye, ear, nose and throat specialist, announces the removal of his office to 310 Connally Building, Atlanta.

The Woman's Auxiliary of the Fulton County Medical Society, Atlanta, has elected the following officers for 1945-1946: Mrs. D. R. Longino, president; Mrs. Hal M. Davison, president-elect; Mrs. Olin S. Cofer, first vice-president; Mrs. Frank K. Boland, second vice-president; Mrs. Homer R. Maulding, third vice-president; Mrs. T. Bollinger Gay, recording secretary; Mrs. Emory G. Lower, corresponding secretary; Mrs. Hartwell Boyd, treasurer; Mrs. W. A. Selman, parliamentarian; Mrs. Dan Y. Sage, historian; Mrs. John W. Turner, auditor.

Dr. Clifton G. Kemper, Atlanta, announces the new location of his offices, suite 1117 Doctors Building, Atlanta.

The Georgia Medical Society held a special called meeting in the society's hall, 621 Drayton Street, Savannah, August 14. Matters of vital importance were discussed.

Dr. Philip A. Mulherin, Augusta, recently discharged from the Army, has taken up his duties on the faculty of the University of Georgia School of Medicine, Augusta, as chairman of the Department of Pediatrics. He has been stationed at St. Louis, where he took a post-graduate course in pediatrics under Dr. A. T. Hartman. Dr. Mulherin will succeed the late Dr. Claude M. Burpee as head of the Pediatric Department of the Medical School. His father was the late Dr. William A. Mulherin, who was also a member of the faculty of the Medical School.

Tulane University of Louisiana School of Medicine, Department of Graduate Medicine, 1430 Tulane Ave., New Orleans, La., announces session 1945-1946 review courses as follows: October 15-20, 1945, Internal Medicine; November 5-10, 1945, Traumatic and Emergency Surgery; December 10-21, 1945, Tropical Medicine and Parasitology; January 14-18, 1946, Obstetrics and Gynecology; January 2-May 25, 1946, Tropical Medicine and Parasitology.

Special courses: February, 1946, Communicable Diseases; March, 1946, Recent Advances in Therapy; April, 1946, Genito-urinary Diseases; May, 1946, Diagnosis and Treatment of Neoplasia.

Dr. D. S. Estridge of Chattanooga, Tenn., has opened an office in the old Masonic Temple Building, Trenton, where he will spend one day each week for the present. He was former medical director for the Tennessee Valley Authority, Gilbert, Ky., and is at present associated with Dr. D. N. Williams, Chattanooga. He plans to finally locate in Trenton and become a permanent resident physician of Dade County.

Dr. Herbert M. Olnick has bought the Clinic Building on Main St., Dahlonga. He is the North Georgia College physician and his acquisition of the present clinic property will represent a permanent and convenient medical center, not only for the college students but also the public, which is an asset to Dahlonga and Lumpkin County.

The Southern Pediatric Seminar met recently at Salluda, N. C. The faculty included the following physicians: Drs. W. L. Funkhouser, Atlanta; Francis B. Johnson, Charleston; William Weston, Columbia; R. M. Pollitzer, Greenville; A. J. Waring, Savannah; Kenneth M. Lynch, Charleston; J. Warren White, Greenville; Philip A. Mulherin, Augusta; Hines Roberts, Atlanta; Mynor W. Beach, Charleston; Julian Price, Florence; and Lee Bivings, Atlanta. The late Dr. William A. Mulherin of Augusta, Ga., was the seminar's first dean.

Dr. DeWitt T. Bond, Danielsville, has recently been discharged from the medical corps of the U. S. Army with the rank of captain, after serving three years with the Army, two years of which were spent in the South

Pacific area. He has opened an office in Danielsville for the practice of medicine.

Dr. Carlos Calero, and Dr. Helvidaro Celis, Mexican physicians, recently spent two days in Augusta, studying American public health organizations. Explaining that Augusta was chosen as a center of observation because of its climatic similarity and health problems akin to Mexican ones, the Mexican physicians also stated that they were primarily interested in malaria and tuberculosis control programs in operation throughout the South.

OBITUARY

Dr. Jackson Cleveland Loveless, aged 55, well known physician of Grayson, died in a private hospital at Atlanta, Aug. 4, 1945. He was a graduate of the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1913. He was a member of the Newton County Medical Society, the Medical Association of Georgia, and the Baptist Church. Survivors include his wife, Mrs. Ada King Loveless, Grayson; three brothers, Joseph Loveless, Atlanta; J. M. and L. J. Loveless, Grayson; three sisters, Misses Mollie and Blanche Loveless and Mrs. L. J. Moon, all of Grayson; two foster children, Mrs. Dorothy Thacker, Conyers, and Joseph A. Favero, Grayson. Funeral services were held from the Snell Baptist Church with Rev. Andrew Johnson and Rev. Williams officiating, and interment was in Mount Zion Cemetery.

Dr. Lyman Sanderson Osborne, aged 90, beloved citizen and physician of Fitzgerald, died Aug. 6, 1945. He was born and reared at Janesville, Wis. He was a graduate of the University of Michigan Medical School, Ann Arbor, Michigan, in 1878. In 1884 he married Miss Annie Laurie Smilie at Waverly, Iowa, and in 1897 he moved with his family to Fitzgerald and has made that city his home since. He was a member of the Ben Hill County Medical Society and the Medical Association of Georgia. Dr. Osborne served the city of Fitzgerald in several capacities, and especially was his work as a member of the school board and as city health officer appreciated. For more than twenty years he was the physician for the Fitzgerald Cotton Mills. Surviving are one son, William Farrand Osborne, East Orange, N. J.; two daughters, Mrs. E. S. Winn and Mrs. J. E. Brewer, both of Fitzgerald; and one sister, Mrs. William Bullock, Oakland, Cal. The funeral services were held from the chapel of the Home Furniture Company, with Rev. Frank L. Elvery, pastor of the First Presbyterian Church, officiating. Interment was in Evergreen Cemetery.

Dr. Eugene Farmer Sanford, aged 55, beloved physician of Buchanan, died at Harbin Hospital, Rome, Aug. 2, 1945. He was born and reared in Haralson County. He graduated from Buchanan High School and the Hospital Medical College, Eclectic, Atlanta, in 1910. Dr. Sanford was a Major in the Medical Corps in World War I, a member of Theta Kappa Psi, a Mason, President of the Haralson County Medical Society and a member of the Medical Association of Georgia. He was a member of the Governor's Staff, had served as Mayor

of Buchanan, and as a member of city council. He was progressive in his ideas and identified himself with every movement for the upbuilding of his town and county. He is survived by his wife, Mrs. Evelyn Shepard Sanford, and his mother, Mrs. R. F. Sanford, both of Buchanan. Funeral services were conducted at the Corinth Baptist Church by Rev. C. R. Campbell, Rev. W. H. Roberts and Rev. C. R. Williams. Burial was in the church cemetery.

Dr. Benjamin L. Smith, aged 63, prominent physician of Forsyth, died at Mercy Hospital, Macon, July 7, 1945. He was a native of Butts County, the son of the late Mr. and Mrs. Wilson Smith. He was a graduate of the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1906. He was a member of the Monroe County Medical Society and the Medical Association of Georgia. Dr. Smith was of a sympathetic nature, and in the course of his practice he did much charity work. An outstanding fact in his record was that he kept no books and never sent a bill for his services. His explanation was, that "if a man is honest, he doesn't need a bill, and if he isn't honest, that he wouldn't pay anyway." His faith in his fellowman seems to have been amply justified, for Dr. Smith prospered throughout his service as a physician, and his place in the affections of those he served was secure. He is survived by his wife, Mrs. Mattie Hardin Smith; one daughter, Miss Velma Smith, both of Forsyth; and two brothers, Dr. J. W. Smith, Juliette, and E. O. Smith of Jackson. Funeral services were held at the First Baptist Church, conducted by the Rev. W. B. Hollingsworth and Dr. Leslie S. Williams. Interment was in the city cemetery.

Dr. Roger C. Swint, aged 70, retired physician of Atlanta, died Aug. 3, 1945. He was a graduate of the University of Georgia School of Medicine, Augusta, in 1893. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, and the American Psychiatric Association. Dr. Swint, at the time of his death, was consulting psychiatrist at Veterans Hospital 48. Before moving to Atlanta he was superintendent at the Georgia State Hospital, Milledgeville, for 25 years. Survivors are his wife, Mrs. Roger C. Swint; two sisters, Mrs. Charles J. Wallace, Miami, Fla.; Mrs. S. B. Trawick, Linton; one brother, S. B. Swint, Atlanta, and several nieces and nephews. Funeral services were held at Spring Hill with Dr. M. Ashby Jones officiating. Interment was in West View Cemetery.

Expert Clinical Interpretation

of

Chest X-Ray Films

CHAMP H. HOLMES, M. D.

P. O. Box 365

Atlantic Beach, Florida

Advertisement



From where I sit by Joe Marsh

Mad Dogs and Wagging Tongues

The county had a "mad dog" scare last week. Phoebe Token's spaniel bit the postman, and he vowed that he was plenty mad about it.

But by the time the rumor got around, it wasn't the postman who was mad, it was the dog. And before the truth was learned, half the kids in the neighborhood had missed school, while their mothers nearly drove Dr. Walters crazy, asking him for advice.

Wagging tongues can cause a lot of "mad dog" trouble. Like the wagging tongues that gossip about soldiers drinking too much around Army camps. There's not a bit of truth in it—as the Government found out and told us.

Milk and beer are a soldier's favorite drinks—which is why we have the best behaved Army in history. But those ugly rumors are bound to hurt morale and cause hard feeling.

From where I sit, wagging tongues can cause a heap more trouble than mad dogs.

Joe Marsh

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, October, 1945

Number 10

HOW GOOD IS NAVY MEDICAL CARE IN WORLD WAR II?

COMMANDER JACK C. NORRIS, M.C.,
U.S.N.R.
Atlanta

Inasmuch as I am a native Georgian, and was a practitioner of medicine in that state before I was called to duty, this will be written in a personal vein, to some extent anyway, because I feel that I am talking, as I write, to more than a thousand friends back home with whom I have worked, and visited, during those happy years before the war. Therefore, I must ask pardon for those expressions which might seem to be of self-praise; and I must ask forgiveness if what I shall write would, or does seem, to place the Naval Medical Department in a sublime spot in medicine, above that which other folks might think was not deserved. I must also insist that what I say does not, or is not intended to take, or reflect discredit on, or belittle those medical services in other branches of the government. They are doing good jobs, too.

Someone might ask: "Why that title above? Has someone condemned the Navy Medical Department?" or "Does it need defending?" I can answer with certainty that the department does not need defending; and to my knowledge no one has seriously criticized it. It is simply a title which gives me considerable leeway in which I can write with pride of the war performance of a great bureau, of which I am a very small part.

This article is written in the great Pacific, about 10,000 miles from Atlanta. At the very moment I am writing, my ship is raising its anchor to go into forward battle zones. We are going to fulfill our mission — to ease pain; to give our wounded boys

immediate help; to save as many lives as we can.

I have spent 18 years of my life in the service of the Naval Reserve Medical Corps, both as a sailor and as an officer, and when teaching at Emory University I had the opportunity, on many occasions, to inform my students of the Naval Medical Service; about what it had to offer in time of peace, and about what it intended to do in time of war. It was during those many informal talks that I perhaps influenced several young men in the Naval Service. Wherever we have been, I have met someone well known, including my former students, and many of my confreres with whom I practiced medicine in Georgia. Many of these are known to all of you, such as Mitchell, Burgess, Dorough, Alden, Hailey, Benson, Hobby, Upchurch, Walker, Wilson, Rogers and others. I can say with pride that all these fellows have continually been on the job. They have done their bit as well as any other group of doctors that I have encountered. The State of Georgia and the nation can well afford to be proud of them. Since war has come I have travelled nearly 100,000 miles. My war experiences began at Pearl Harbor and have extended to the Okinawa area near Japan. Most of that time has been spent on hospital ships, over-sea stations and hospitals, and Naval hospitals on far-flung islands, as well as including first aid stations, dressing stations, evacuation stations, fatigue stations, clinics, sanitation and research units. In fact I have seen about all there is to see, including all the tragedies of war from artillery duels to dive bombers; and have encountered every type of casualty incident to battle.

With the preceding thoughts in mind, and if the personal references will be accepted in the light in which they have been written — largely to give a historic back-

ground for my paper — then I feel that you will not consider me inadequate to tell you something about Navy medical care. In addition, this paper shall serve to let my friends know that regardless of the Nipponese I am still very much alive, and fully intend to stay so.

The Navy Medical Department functions under the Bureau of Medicine and Surgery. The administrative head of the Bureau is Surgeon General Ross T. McIntire, whom many of you personally know. It is broadly organized into the Research Division, Professional Division, Material Division, Planning Division, Division of Aviation Medicine, Physical Qualifications and Medical Records, Procurement, and Division of Dentistry.

The Bureau of Medicine and Surgery was established in 1842 and it is one of the oldest systematic departments of the Navy. The growth of the department is astounding. Its total membership, including medical officers, dental officers and others, comprises a group that number more people than were in the entire Navy prior to Pearl Harbor.

Those divisions of greatest interest to the average doctor are the Division of Preventive Medicine, which includes units dealing with communicable diseases, sanitation, and audiovisual medicine; and the department known as the Professional Division, which includes medicine and surgery, tropical medicine, and hospitalization. The Department of Neuro-Psychiatry and the Physical Branch are also contained in this latter group. The Professional Division has also undertaken steps to concentrate on the treatment of such diseases as malaria, filariasis and rheumatic fever.

Another department of significance is the Naval Medical Research Center. This unit has one of the finest equipped research buildings in the entire country, and its staff is continually adding to the sum of knowledge in research. Many valuable contributions have been made during the present war, such as a drinking kit for making sea water potable, flash ointment to protect from fire, stretch floats for air-sea rescue, salt tablets for tropic use, and many others. Eighty-six investigations and ninety-

four reports have been published by this department on investigative problems during 1944.

The Navy does not entirely confine its activities to the members of its personnel. The bureau has gone to considerable trouble in order to attend to the health of all its people; and hospitals have been designated within the states and elsewhere for the care of sick dependents. This program includes 22 hospitals and 18 dispensaries that render medical service, and is of considerable aid to the enlisted group, because it offers economical medical care to them.

The Navy Department is bound closer to all our people today than ever before in its history; not only are the men comprising it from every city and town and state and territory from all ranks of professional life, among whom can be found some of the foremost surgeons, psychiatrists, public health authorities, bacteriologists, and chemists in the world; but the Surgeon General early in the war also invited a fine group of civilian physicians to act as advisers, among whom are such men as Dr. J. E. Paullin, Professor of Clinical Medicine, Emory University, and Dr. Frank Lahey of Boston, who is one of the country's outstanding surgeons.

It is impossible, all-in-all, to briefly describe the many duties of the Bureau of Medicine and Surgery. I would emphasize that treatment and disease prevention are its most active functions, including hygiene and sanitation afloat and ashore. When the final reports of this activity are compiled the work will be of world-wide importance.

For actively treating the sick and injured, there are approximately 13,000 medical officers, 6,000 dentists, 12,000 nurses, and 130,000 hospital corps officers and men. There are 12 hospital ships, 53 large state side hospitals, and numerous clinics (foreign hospitals not included). In this vast organization, there also are many general practitioners and specialists, who can do everything demanded of them, from delivering a native woman's baby, to pulling the teeth of a *High Talking Chief* while on some remote Pacific island. At the

onset of the war, the Navy was flooded with specialists but the demands upon Navy medicine and surgery have caused a new era to enter their lives, and dermatologists have had to become administrators of anesthetics or sanitation officers; and the general practitioners have again had to learn how to do an appendectomy. Urologists have become experts in treating burns. However, nothing will be lost through this strange change in their medical activity, for the government has taken steps making it possible for these men to take post-graduate courses after the war, so that they might relearn their former work in its latest phases.

During most of my Naval duty I have been at sea, on two of the finest hospital ships in the world. I have visited many of the Navy's far-flung ports, and have yet to find a place where good Naval medical service was unavailable. The ship to which I am now attached is a 10,000 ton recon-verted vessel that can carry at least 650 patients, both stretcher and ambulatory in type. It is equipped with the finest x-ray machines. There are also air-conditioned operating rooms, elevator service, and bunks with very comfortable mattresses on them. Sixteen doctors and 21 nurses are aboard, with 150 hospital corpsmen, and a line crew of approximately 275. The staff is trained to work largely with acute casualties and we can take aboard 600 patients in about four hours or less time, in such a manner as to assure every patient almost immediate attention.

The patient problem is handled in the following manner: At beachheads small boats, such as the Higgins Boat or amphibious jeeps or ducks, come alongside with patients. A trained group of men immediately enter this boat, and the stretcher is carefully and gently but quickly pulled aboard. When necessary, four of these lifts can be in operation simultaneously, while ambulatory patients come aboard via the gangway. Quite a different problem is concerned with bringing patients aboard on the open seas and while underway. The transfer may be made from a ship of most any class — a destroyer escort, aircraft carrier, or 54,000 ton battleship — but in

all the procedure is much the same. Bow lines are thrown, secured, and a pulley or trolley arrangement is set up. And then the patient's baggage or gear is sent across. The passenger follows. If a bed patient, he is secured in a Stokes' stretcher and swiftly, easily swung up, outward and over the turbid waves in a exciting "sky ride." The ambulatories traverse the distance suspended in a seat arrangement.

One ship after another or two at one time may come alongside in this manner to discharge their sick and wounded to the hospital ship. In fact, this duty is, in the true sense of the words, "servicing the fleet."

The patient is met on the main deck by a medical officer who immediately ascertains his type of injury, and directs him to a ward. If he is in shock, the shock team meets the patient at once, and by the time he has been placed in his bunk (and often before the clothing has been removed) he is receiving blood and plasma into his veins. Blood can be given immediately, or is never delayed more than 15 minutes. Plasma is given at once. These solutions are often reinforced with solutions of dextrose and saline, and are sometimes administered simultaneously. Every attention is centered on overcoming *shock* and as soon as the shock state has been reversed the patient is carried to surgery. On occasion, the patient is carried directly to the operating room, and the entire procedure undertaken there. This, in brief, tells the story; and with blood and other derivatives we have seen many lives saved. We feel that the immediate transportation of the patient to the first-aid medical units, the prompt relief of pain, the control of hemorrhage, the elimination of infection by using sulfa and penicillin, to be the main story in the management of war injuries. To this routine, of course, must be added the values of good surgery, and orthopedics.

The burn patient still presents our most difficult problem, yet things have gone a long way forward in the treatment of these cases. Plasma at first, proper surface bandaging, control of pain through the careful use of morphine; the administration of *blood, blood, blood*, especially after the

third or fourth day of illness, saves many of these men. We have seen men live with as high as 80 per cent first degree burns.

Chest wounds demand skill and experience. Too quick withdrawal of blood from a bleeding pleural cavity may kill one; too much allowed to remain might kill one. Excess blood given by vein sometimes increases the bleeding. So there you are. This is no problem for the inexperienced doctor, but instead for one who has learned the hard way. The abdominal wound cases can often be saved with prompt operation and penicillin. Fractures of the spinal cord bring us real grief; there is little hope for them. If they live, most are doomed to be paralytics.

In retrospect, the methods of medicine and surgery in this war are quite different from those employed in World War I. I remember an epidemic of cerebrospinal meningitis in 1918. A large percentage of the patients died, including nurses, doctors and corpsmen. Now I am sure that cerebrospinal meningitis can be managed successfully (unless the Waterhouse syndrome appears) and quicker than the ordinary common cold. Insulin has removed the coma of diabetes. Sulfa has managed the pneumonias (excepting virus types) and preventive inoculations have protected us from typhoid, tetanus, cholera, plague and smallpox. Atabrine will suppress malaria. DDT will help control the spread of filariasis, malaria and yellow fever. It is an amazing thing to never have to worry about such a killer as tetanus. Not a proved case has been seen in a sailor since the war began. In the last war, ward after ward used to be filled with men who had venereal diseases. Now, through prophylaxis and education and with the use of penicillin and sulfadiazine, these wards are almost empty!

Gas gangrene is another killer that has been controlled. We have a modified method of Altemier's culture for *B. Welchii* which become positive in active cases as early as four hours after taking the culture (report in Bulletin, BM&S). If positive, with active symptoms, the patients are given polyvalent gas gangrene antiserum in conjunction with intravenous penicillin.

When suspicious cultures are obtained, and symptoms are not definitely active, then we give 40 60-80,000 units of antiserum, while watching carefully for active symptoms, being guided largely by the pulse rate and temperature. Since this culture method and treatment routine has been evolved, we have not had a single death from this malady.

I have discussed briefly the organization and management of some of our routine surgical and medical matters. However, those are not the only problems that worry or confront the Navy doctor. The psychiatrist aboard ship or at a station, is a mighty busy person, and sometimes his troubles seem insurmountable. He is called on to study, cure or make dispositions of all types of nervous conditions, including fright, hysteria or insanity. Battle fatigue usually cures itself with a few days of rest, sleep and food. Fright can be overcome by the assurance that it is a natural, normal reaction, and the more activity the fighter encounters, the sooner will he overcome it. Other problems also require much tact and understanding of human relations. To illustrate, a boy was sent over to the doctor with a letter from an authoritative source which read:

"Dear Sir:

"The above man has written home saying that he is sick and in need of medical care. His mother is ill and is very much distressed about him. Will you please investigate?"

The lad was a nice looking fellow, and appeared to be intelligent and healthy. He liked his ship and his job. Careful investigation showed that he was not sick or injured, and never had been. Neither had he been exposed to unusual exigencies of war. In fact, he had what he admitted was a case of "states-itis." After an understanding talk he felt better. He was assured that his work was important. His skipper did not want to lose him. He felt much better after the interview when he was told that he was not alone in wanting to return home, but that we couldn't afford to go home if the Navy couldn't replace us. Afterwards he promised that he would not write worrisome letters to his mother.

There are also other difficulties which wear one considerably. Doctors want most of all to prevent death. Every death leaves him with a pang of regret because it is hard to see brave young men die, but it is an inspiration to see how they go. No fright, no crying, no unusual emotional display; most of the time, collected and quiet, without great regret. One told me, "Don't notify

my wife, Doc, it would only make her unhappy." Another said, "Most of all, Doctor, I would like a cool glass of beer." In a few minutes he was with his Maker. One day I was attending one of the most terribly wounded men I have ever seen. One leg shot away, an arm blown to pieces, other leg splintered, face shot away, eyes out! He said to me, "Doctor, is there a Catholic chaplain aboard? If so, send him to me." I inquired if there was anything else that he wanted, and he asked that his pain be made as easy as possible. When he died he was having everything done for him that was possible — pain controlled, blood flowing into his veins, warmth applied, oxygen inhalation. This entire tragic panorama took place within an hour's time. He died peacefully.

Another one was a young aviator. He had a burned body surface of more than 50 per cent, including his face, arms, and legs. His legs had third degree burns from hips to ankles. He seemed doomed to die. In a critical condition, he was aboard for four weeks. During this period, he received the following treatment:

Special night and day nursing. Three doctors were in consultation and giving personal attention. His medication consisted of 19 tubes of oxygen, 2,000,000 units of penicillin, 80 grams of sulfa, $4\frac{1}{2}$ grains of morphine, several grains of codeine, 11 bottles of plasma, two bottles of serum albumin, 50,000 cc. approximately of fluid by mouth, 14,000 cc. of saline and dextrose intravenously, 30 pints of blood (12,960 cc.), and 5 pounds of sulfa ointment.

In addition, he had x-rays, dressings, and numerous laboratory procedures. The problems he presented were at times almost too great to overcome. During the last week blood could only be given by using the femoral veins, as no other ones could be found. He left the ship alive! When he came to us his first remark was, "I am so glad that I was able to complete my mission and return to my ship." His burns he attributed to bad luck in getting out of a burning plane, which exploded when landing on the flight deck of his carrier!

I can close this paper with a deep feeling of sincerity when I say to my confreres and to every mother and father in the Nation who has a son in the Navy, "So worry not; your son has the best war medical service in the world." I am comforted also in this thought because I not only have seen what I write about but tonight, as I pen this paper, my only son is sailing toward the shores of Japan. If he is wounded, I know

he will be cared for as quickly and as thoroughly as is humanly possible, and that with modern Naval medical and surgical care he has 97 chances out of a hundred to live and to come home!

ANGINA PECTORIS

JEFF L. RICHARDSON, M.D.

Atlanta

Angina pectoris literally means pain in the chest accompanied by a feeling of suffocation. Actually, the term is used to denote a classical type of pain that is associated with heart disease. The classical attack is a sudden onset, after effort, of substernal pain that is aching or crushing in character, that radiates to the left shoulder and down the inner aspect of the left arm, that lasts five to twenty minutes, and is promptly terminated by the administration of nitroglycerine. Variations occur as to radiation, the pain may at times radiate to the right arm, to both arms, or, to the jaws. The seat of the pain however is substernal. The fact that the pain is substernal demands emphasis, for pain that is precordial or in the left lower chest is seldom of cardiac origin and never angina. Pain in the left lower chest that the patient usually complains of being "pain around the heart" may be neuralgia, myalgia, pleurodynia or other conditions. In most instances, however, it is due simply to gas in the splenic flexure of the colon. No uniform changes occur in the pulse rate, blood pressure, or heart sounds during the anginal attack, and the diagnosis rests entirely upon the description of the attack given by the patient.

Occasionally one sees attacks of angina that do not terminate in a few minutes but may last hours. This type of pain has been termed the pain of "coronary failure" by Blumgart,¹ as it is always associated with advanced disease of the coronary arteries. It is in fact merely a severe form of angina that differs from the classical attack only in that it lasts longer and that it does not respond to nitroglycerine, morphine usually being necessary for relief.

Read before the Medical Association of Georgia, Savannah Session, 1944.

The treatment of angina is dual, consisting, first, of the treatment of the attack, and second, treatment directed at preventing further attacks. The treatment of the individual attack is simple. Frequently they demand no treatment but pass off in a few minutes when the patient ceases his activity. They are at times relieved by belching and are always relieved by the administration of nitroglycerine, gr. 1/200, under the tongue.

The prevention of the attacks is more complex and to follow the proper therapeutic avenue one must understand the mechanism of the attack. That the attacks are due to a transient myocardial ischemia is generally accepted. This ischemia was formerly thought to be due to a spasm of the coronary arteries and there are at present some men who adhere to this theory.² While some attacks are undoubtedly due to spasm of the coronaries, in most instances this is not the mechanism but the cause of the ischemia is simply a demand by the myocardium, at the time, for more blood than it receives. While in most instances this is due to narrowing of the coronary arteries, it is not always true. For example, the enlarged heart associated with hypertension, and laboring under the load thrown upon it by a high diastolic pressure, may receive an adequate blood supply while the patient is at rest. However, after exertion, when the rate is increased and the myocardium demands more blood, the coronaries are not capable of meeting the demands of this large muscle mass, although they may not be diseased to any extent. A temporary ischemia then follows which is responsible for the attack of angina. The same applies to the heart in hyperthyroidism. At times both the heart and the coronaries may be normal and angina may occur as a result of an anemia. The myocardium simply does not get the required amount of blood at the given time.

With this mechanism in mind, prevention of attacks of angina is also dual in that it consists, first, in taking all of the strain possible off of the heart, and second, in improving the coronary circulation, if possible. In taking the strain off the heart the patient must avoid exercise that he knows will produce the attack, must avoid

excitement, and must get an adequate amount of rest. The diet should be frequent small meals to avoid distention of the stomach. If the patient is obese a low caloric diet is advised. Foci of infection, particularly an infected gallbladder and abscessed teeth, should be eliminated. Glandular therapy in women going through the menopause is helpful, and recently good results have been obtained by some by the administration of testosterone to men. If the patient has hypertension, measures directed at lowering the blood pressure are the first consideration. All of this, of course, means that the patient should be put in the best possible physical condition.

In regard to improving the coronary circulation, various operations consisting in grafting the omentum or pectoral muscle on the myocardium have been done but these are still in the experimental stage. The so-called coronary dilator drugs have been praised by some authors and condemned by others. Of these aminophyllin and theophyllin are probably the most popular. In my own experience they were given a thorough clinical trial and as no improvement in any patient was noticed they were discontinued. Digitalis is thought to improve the coronary circulation in heart failure and in impending heart failure and I have used it in patients with a tachycardia with decidedly beneficial results. Several years ago Dr. W. W. Blackman, of Atlanta, suggested to me that the coronary circulation should be improved by treatment with diathermy. He felt that by dilating the small anastomosing channels between the two coronaries daily with diathermy over a period of three to four weeks, a better collateral coronary circulation would result. This was sound reasoning as usually only one coronary artery is severely diseased and if the small branches of the other could be dilated a better coronary circulation would naturally follow. Clinically this was proven to be true, and in certain cases of angina associated with coronary disease diathermy has been most effective. A preliminary report of this treatment was published in 1937.³

REPORT OF CASES

In the past 15 years I have collected 52 cases of angina that I have been able to follow long enough to enable

me to draw definite conclusions as to the results of their treatment. In presenting these 52 cases I have grouped them according to the condition or the mechanism that was responsible for the attacks. In 2 cases the angina was due to hyperthyroidism. Both of these were relieved by thyroidectomy. In 1 case the attacks were due to an anemia. In this case the attacks ceased when the blood picture was improved. One patient was seen in an anginal attack and died before any therapy could be instituted. At autopsy he was found to have a luetic aortitis. The mouths of the coronaries were not narrowed by the aortitis and in this case I feel sure that the angina was due to spasm of the coronaries. This case is the only one proven to have died in an anginal seizure although one other case is doubtful.

Hypertension

In 17 cases hypertension was present. Treatment in these was directed essentially at lowering the blood pressure. Three of these also had syphilis. The syphilis was of course treated but it was not thought in these 3 cases to have a part in the production of the angina. It was felt in all 17 that if the blood pressure could be lowered, and this load removed from the myocardium, the patient would then be relieved of his attacks. This was found to be true. In 6 cases there was a drop of blood pressure, after treatment, to normal or near the normal. All of these were relieved of their attacks. In 3 cases there was a moderate drop in their blood pressure. These were improved but not relieved. In the remaining 8 cases the blood pressure stayed up and they all continued to have their attacks. All are now dead, 3 dying of myocardial failure, and 5 dying of coronary thrombosis. In treating these cases the usual routine for hypertension was used. All of the popular drugs for high blood pressure were tried but potassium iodide in combination with phenobarbital was found to be the most effective and the easiest to administer. Those cases that did not respond to this combination did not respond to and other drugs.

Angina Preliminary to Coronary Thrombosis

Feil⁴ in 1937 published a report of cases of substernal pain that were a preliminary to coronary thrombosis. This differs from the classical attack of angina in that the attacks come on at times while the patient is at rest and they rapidly become more frequent and severe over a very short period of time, a few days to a few weeks. Eleven cases fall in this group. These did not respond to any treatment whatever and all had an attack of coronary thrombosis within a short period. Seven of these died in their attack of coronary thrombosis, 4 survived and have had no further anginal seizures. This type of angina is important from a therapeutic standpoint only in the recognition that coronary thrombosis is impending. Provisions were made in each of these cases to give immediate treatment when the attack of thrombosis occurred.

Coronary Sclerosis

Eleven cases had normal blood pressures and evidence on physical examination and in the electrocardiogram of coronary sclerosis. These were treated with diathermy in an effort to improve their coronary circulation. The results in this group were excellent and 9 of these 11 cases are free of their attacks and are living a normal life. Two died of coronary thrombosis but they

were relieved of their attacks for a period of five and seven years respectively before they had coronary thrombosis.

Following Coronary Thrombosis

Seven cases had coronary disease and had previously had an attack of coronary thrombosis. These were also treated with diathermy. The results however were not as good as in those who had not had coronary thrombosis. Of these 7 cases, 3 were relieved of their attacks and have been free of them for an average period of 5 years. The other 4 showed some improvement but all died with a second attack of coronary thrombosis after an average period of one and one-half years.

Myocardial Disease

In 2 cases which have previously been reported⁵ the mechanism could not be determined. These 2 were both men who had a moderate degree of arteriosclerosis, normal blood pressure, no electrocardiographic evidence of coronary disease, but both had a pulse rate of 90 and a slight amount of cardiac enlargement. Both of these were relieved of their attacks after a therapeutic dose of digitalis. One of these died seven years later of coronary thrombosis and the other is still free of his attacks after ten years.

Summary

To summarize: Out of 52 cases of angina that have been presented, 26 or 50 per cent are free of their attacks and are carrying on a normal existence. Three have been improved but still have occasional attacks. Twenty-three, or 44 per cent, have died which bears out the impression that angina is an ominous symptom. The fact, however, that 50 per cent have been relieved of their attacks and that all but 7 cases showed temporary improvement is encouraging. I feel that these results support this method of treatment of angina pectoris which is to consider angina merely the symptom of some underlying condition and to treat that condition.

REFERENCES

1. Blumgart, Herrman L.; Schlesinger, Monroe J., and Davis, David: *Am. Heart J.*, 19:1, 1940.
2. Fenn, G. K.: *M. Clin. North America*, Jan. 1944.
3. Blackman, W. W., and Richardson, Jeff L.: *Arch. Phys. Therapy*, 19:412, 1938.
4. Feil, H. *Am. J. M. Sc.*, 193: 42, 1937.
5. Richardson, Jeff L.: *J. M. A. Georgia*, 24 (March) 1935.

MORE MEDICAL BROADCASTS

Lederle Laboratories, Inc., a unit of American Cyanamid Company, has renewed for another year its professional service radio program "THE DOCTORS TALK IT OVER" which is heard weekly coast-to-coast over the American Broadcasting Company network on Tuesday nights.

The program has pioneered the use of the mass medium of radio to ethically present information to the members of the medical and allied professions and the public at large on important medical subjects of the day. Many thousands of reprints of the broadcasts have been requested by professional listeners, and the program itself is translated into Spanish for re-broadcast in Latin America.

RECENT ADVANCES IN THE TREATMENT OF RESPIRATORY DISEASES IN INFANTS AND CHILDREN

WM. WILLIS ANDERSON, M.D.

Atlanta

Respiratory diseases make up about one-third of the work of the pediatrician. In this paper attention is called to some of the more common differences of respiratory diseases in children, as compared to adults, and advances made in treating them.

Acute coryza is notoriously common in children. Infants and small children have practically no immunity to colds. If some twenty children in a school room are exposed to a child with a cold, nearly every single one of them will "catch a cold." Recent studies, notably those of Dochez and his collaborators, indicate that two factors are concerned in the production of a cold: one, a filterable virus which initiates the infection; and secondly, the common pyogenic bacteria of the upper respiratory tract, as streptococci, pneumococci, influenza bacilli, staphylococci and others. In the presence of the virus infection these organisms flare up; they doubtless contribute to the inflammation of the nose, throat and larynx and they alone are responsible for such complications as sinusitis, otitis media and bronchitis.

The immunity which follows an attack is relatively short, being from three to seven weeks. The loss of an immunity is gradual. A partially immune person may acquire the virus and harbor it for some time; only when his resistance becomes lowered is an attack precipitated. Exposure to cold is an important factor in lowering resistance. On the other hand, individual children vary greatly in their susceptibility to colds and in the severity of the symptoms they display, so that many factors responsible for these differences in resistance still are obscure.

At times an acute coryza is only a symptom of some more serious disease. A large number of the acute infectious diseases, particularly the acute exanthemata, as measles, scarlet fever, etc., are ushered in

with symptoms of a severe coryza. Naturally, under such circumstances it would be unwise to try to treat such a coryza other than to give symptomatic relief.

Again, there are certain complex diseases, such as rickets, in which children have colds almost constantly, particularly during the winter months. The chest becomes deformed; the respiratory muscles are not as strong in rickets as in normal children, so that the usual expansion of the lungs is interfered with, thus predisposing to respiratory infections, particularly bronchitis and pneumonia. In this way, although rickets itself is not the direct cause of death, it is an important factor in increasing the mortality rate for children in the first two years of life.

The patient with a cold should be isolated, particularly when there are younger children, or infants, in the family. For infants much can be done to avoid digestive upsets by a prompt reduction in diet. Children quite frequently refuse food under such circumstances. Fluids should be given freely. Sedatives are indicated when there is a distressing cough, or when sleep is interfered with. If fever and constitutional disturbances are present, the patient should be kept in bed and given simple fever mixtures, as aspirin and empirin. Dover's powder (*pulvis ipecacuanhae et opii*) act both as an expectorant and as a sedative, and will frequently prove sufficient to control the accompanying cough.

Infection, Malnutrition and Secondary Anemia

Quite frequently in the field of pediatrics not only respiratory diseases but infections elsewhere in the body will be accompanied by malnutrition and secondary anemia in infancy, and particularly in later childhood. Such a child will have colds all winter, he will not gain weight, and continues pale and white. He must be treated from all of these viewpoints, and not from the infectious processes alone. Tonics of iron and, when necessary, combined with vitamins are used with other hygienic measures, as daily rest periods, avoidance of fatigue, ultraviolet radiation and transfusions when indicated. Over a long period of time immunity to colds can be built

up by "cold" vaccines. A series of three or four doses about every third day should be used. These should precede the calculated time that the child has colds, i. e., if an acute exacerbation occurs about every two weeks, the vaccine should be given at slightly shorter intervals, as about every ten days. As the child becomes stronger, and develops more immunity, the interval between the series of vaccinations can be gradually lengthened.

Another unusual pediatric problem is the types of pneumonia caused by aspiration of oil. The causative agent is a lipoid, or a lipid, substance entering the lungs through the mouth, the nose or through a tracheotomy opening. Responsible oils are halibut and cod liver oils, milk and egg yolk, vegetable oils, such as castor oils, olive oil, wheat germ oil; and mineral oil, such as liquid petrolatum. Among the predisposing conditions may be mentioned: perforated palate; forceful feedings in either crying children or those who are debilitated; neurologic conditions at any age causing dysphagia, such as multiple sclerosis, brain tumors, etc.; and upper respiratory infections treated by intranasal administration of oils. The pathologic picture is a low grade, interstitial, proliferative type of inflammation of the lungs with a foreign body reaction. Severity of reaction depends somewhat on the type of oil. Vegetable oils are least toxic and least irritating, producing a slight degree of reaction. Pure vegetable oils, such as olive oil and cotton seed oil, lie free in the alveoli, producing no symptoms, and may be largely removed by coughing. Chaulmoogra oil, a vegetable oil, is very damaging on account of its high fatty acid content. Animal oils are the most dangerous, the most toxic being cod liver oil. Liquid petrolatum is chemically inert and acts purely as a foreign body in the parenchyma.

Clinical signs of oil aspiration pneumonia are indefinite and not characteristic. The most common symptom is cough. The temperature is usually normal. Pain is absent. X-ray study shows increase in size and density of the hilar shadows and lung markings. These signs, which show little or no change in appearance in subsequent

x-ray examinations over a period of time, with cough, no fever, and difficulty in swallowing should establish the diagnosis.

Other forms of aspiration pneumonia include the inhalation of powders, particularly stearate of zinc. The quantity inhaled may be sufficient to cause immediate death; in other instances violent coughing and dyspnea are produced and showers of fine crackling rales may be heard, especially at the bases posteriorly. All powder containers containing stearate of zinc should be so labeled and an automatic opening placed on each container so that it would close when the opening is released.

Small children occasionally ingest kerosene, mistaking it for water. It is rapidly absorbed and excreted through the lungs where it appears to cause local irritation and diffuse pneumonia. These patients are cyanotic, in part from the pneumonia and in part from methemoglobin formation. Most cases of kerosene pneumonia recover uneventfully in the course of a few days.

When we are called at night by a mother who says her infant has croup, the chances are that he has croup. It is important to bear in mind, however, that this may be the start of a far more serious disease, acute laryngotracheobronchitis. Diphtheria, of course, should also be borne in mind.

Acute laryngotracheobronchitis may usually be distinguished from simpler and milder forms by the fact that the symptoms are progressive and persistent. If the symptoms do not respond quickly to steam and an expectorant the child should be hospitalized since the disease is not simply a laryngitis but an inflammation which extends from the throat down to the bronchi and possibly to the bronchioles. In the early stages of the disease there is swelling of all these tissues so that the airway is restricted. Later necrosis and sloughing of the membrane and plugging of the bronchi may develop with resultant atelectasis and emphysema, and possibly pneumonia. The mortality from this disease is from 50 to 100 per cent, and it is a real pediatric emergency. Treatment includes placing a child in a moist room, oxygen administration, tracheotomy if indicated, sulfanilamide,

penicillin and similar supportive measures. Transfusions seem to help some infants with staphylococcic infection. Fluids are given by mouth in moderate amounts, although one should avoid flooding the patient with liquids. Morphine and atropine are absolutely contraindicated, as morphine suppresses the respiratory effort and atropine dries the secretions.

Tuberculosis in young children may appear as an acute respiratory infection. Any child whose illness takes on an unusual clinical course should be tuberculin tested. The protein pure derivative is practically 100 per cent in its reaction.

X-ray examination of the chest of young children is always instructive. X-ray has shown that pneumonia in young children is rarely lobar and that lungs frequently develop small and large areas of collapse (due to plugging of the bronchi or bronchioles); it has disproved the common statement that central pneumonia is late in manifesting itself, for it manifests itself early because the area of consolidation is in contact with a bronchus. X-ray examination frequently will not definitely distinguish between acute bronchitis, disseminated pneumonia and interstitial bronchopneumonia. These can best be diagnosed by clinical examination.

The onset of respiratory infection in children may be masked by a disturbance of other systems. In infants all infections may begin with gastro-intestinal disorders; gastro-enteritis in infants should be regarded as a symptom of other infection until it is proved not to be. In nearly every instance acute tonsillitis is ushered in by some gastro-intestinal upset. In older children the onset of an acute respiratory disorder may simulate meningitis or appendicitis. Frequently a child with acute otitis media gives every appearance of acute meningitis and only after a lumbar puncture is done and the ear drained can a differential diagnosis be made. In addition to sulfanilamides and, more recently, penicillin, good nursing, frequent changes of position of young infants and frequent administration of fluids are essential. Cyanosis is an absolute indication for oxygen therapy. If trouble is anticipated oxygen should be

given early before cyanosis develops. Steam should be used in acute obstructive dyspnea. In recent years we have also learned that the addition of vitamins to other treatment will shorten the duration of otherwise long drawn out illnesses.

EARLY CONGENITAL SYPHILIS

Diagnostic Criteria and Penicillin Therapy

EDWIN R. WATSON, M.D.

Macon

Because of the increasing interest in early congenital syphilis, this article has been prepared with the idea of summarizing diagnostic criteria and commenting upon the use of penicillin therapy. This is not an attempt to report any special study but is rather an effort to ferret out published and unpublished data pertaining to the subject.

Nothing is more important in the treatment of congenital syphilis than early and accurate diagnosis. A comparison of results obtained from early and adequate treatment with results secured in treatment of late cases illustrates vividly the importance of detecting and treating early cases. No amount of treatment can correct the results of certain destructive processes which often occur in inadequately treated or untreated late cases.

It is also essential that treatment be delayed until diagnosis, based upon acceptable criteria, has been made. No child should be placed under treatment until diagnostic procedures indicated have been fully utilized and evaluated.

Every child born of a syphilitic mother, whether the mother has been treated or not, is potentially a syphilitic infant and should be proved either syphilitic or non-syphilitic. To do so is not always an easy task but unless this be done as a part of postpartum care the opportunity to detect the case early may be lost. A syphilitic infant may not develop clinical signs or symptoms of the disease which would result in the child being placed under a physician's care. The mother may note some lesions but too often ignores them.

It should be recognized that the placental barrier may in itself prevent the spirochete from entering the circulation of the fetus. A second protective measure is to be found in adequate treatment instituted early in pregnancy. However, treatment of the mother following infection of the fetus in utero does not assure that the infant will be free from syphilis. Since neither of these protective measures may suffice, it is essential that the potentially syphilitic newborn be appraised.

Appraisal of the potentially syphilitic infant is time-consuming if all criteria of diagnostic import are applied. In one instance the placental barrier to infection is not a barrier to the transfer from the mother's circulation to that of the fetus of the substance called reagin, which gives rise to a positive serologic test. Therefore, the newborn infant may have a positive serologic test and yet be non-syphilitic. Six weeks or longer may elapse before these pseudo-positive tests fade. In other cases, the infant with negative serologic test at birth may develop a positive serologic test after several months have elapsed. Obviously the serologic test during the early newborn period is not reliable, particularly when performed as a qualitative rather than as a quantitative test. It should also be borne in mind that false positive tests occur which may not be related to syphilitic disease.

Perhaps a word should be said about the quantitative test. Only a few laboratories in Georgia are currently performing quantitative tests for syphilis, but there is no reason why many hospital laboratories with adequately trained and experienced personnel could not make this service available to local physicians. Physicians are acquainted with the fact that agglutination tests vary in titer due to the concentration of substances responsible for a positive test.

The same principle applies in the serologic test for syphilis, i.e., the sera may be positive to a varying degree, and by quantitative test is meant the measurement of the titer. The usual method is concerned with the dilution of serum until it ceases to produce a positive test. The titer is commonly expressed as the highest dilution of serum

that produces a positive test. If, when the serum is diluted 1:50, a positive test is obtained but the test is negative when serum is diluted 1:60, the serum is said to have a titer of 50. The same result may be expressed as either a titer of 50 or as Kahn units by multiplying same by 4, thus expressed as 200 Kahn units. When *undiluted* serum gives a partial flocculation, the result may be expressed as 1, 2, or 3 Kahn units. The tendency for serum titer to vary from day to day makes it necessary to have a change of at least one dilution in order to be significant. The serum titer may change within a short period of time and, for this reason, by measuring change in titer, syphilitic activity in the absence of clinical findings may be measured. This is important in following up results of treatment or in making a diagnosis when only a change in titer will indicate syphilitic infection. Within a short period of time measurements of titer may be observed that would require months or years to determine by qualitative test alone. A falling titer in the absence of treatment may indicate a fading false positive reaction.

To exclude the presence of syphilis in infants, one would:

First, concern oneself with the presence and duration of the disease in the mother because this information is often helpful in determining status of infant.

Second, make repeated, careful, clinical appraisal of the infant, paying particular attention to those signs and symptoms that characterize the disease in early infancy.

Third, make a serologic test. If test is positive and yet no clinical signs are present, treatment should be delayed until qualitative serologic test is reliable in the absence of quantitative methods. If quantitative method is available, a test on both mother and infant should be made. If, in the absence of clinical findings, the infant's titer is no higher than that of its mother, the test should be repeated at intervals until it is established that the titer is rising significantly or remains high, which would indicate an active syphilitic process in the infant. A rapidly falling titer or reversal of serologic test during first 6 weeks of life indicates that test was positive because of

transfer of reagin from mother to infant through placental circulation. When inadequate serologic results indicate presence of the disease during early infancy, it is safe to await further appraisal because usually only a few weeks are required to establish diagnostic criteria. A *short* delay in such symptomless cases will not affect results of treatment if treatment is instituted immediately upon making a diagnosis.

Fourth, use darkfield technic whenever possible because when appropriate lesions are present it is not difficult to obtain a positive test. When positive, this single test presents indisputable evidence of syphilis and is in contrast to other criteria which have relative value.

Fifth, employ x-ray. This procedure has many pitfalls, however, for the infant may be luetic and yet fail to show any bone changes. The tendency for syphilitic bone lesions to heal spontaneously in the absence of treatment may cause the process to disappear before x-ray examination is made. Therefore, only positive findings are of diagnostic value. Frequently, the existence of periostitis is erroneously accepted as a sign of lues. The presence of thickened periosteum is often detected in lues as well as in other diseases of infants. However, periostitis is often a prominent finding when other syphilitic bone pathology is demonstrated by x-ray. The presence of osteochondritis and osteitis is diagnostic of congenital syphilis when diagnosed by a qualified roentgenologist. The diagnostic lesions may not produce clinical findings (bone tenderness, thickening, etc.) yet be quite pronounced by x-ray. Frequently, diagnostic bone lesions are present in early infancy and may establish a diagnosis at once. The extremities more commonly show bone changes and the medial and upper aspect of the tibia and lower third of femur are most commonly involved. Changes in the upper extremity, with involvement of distal part of radius and ulna, may occur without involvement elsewhere.

When the foregoing criteria have been applied without establishing a positive diagnosis during the first six months of life, it may be assumed that the child is not syphilitic, at least until further observations

indicate otherwise.

It should be noted that treatment sufficient to secure disappearance of clinical signs of syphilis or even reversal of blood serologic tests may still not be adequate to arrest invasion of the cerebrospinal system by the spirochete pallidum. Therefore, every infant or child should be thoroughly studied for evidence of neurosyphilis before treatment is discontinued. To determine activity of syphilitic process in the nervous system, it is necessary to perform a lumbar puncture and to examine the spinal fluid to determine cell count, protein, serologic reaction and mastic or gold curve. It is not advisable to attempt to evaluate syphilitic activity in the cerebrospinal system solely on the basis of serologic result obtained with spinal fluid because the serologic result may be positive yet the process be an inactive one. A complete examination and often repeated examinations of the spinal fluid are required before a diagnosis can be conclusive. A lumbar puncture is essential for each case and should be done several months following treatment and before dismissal of the patient. In this way, *special treatment* for cerebrospinal syphilis can be initiated immediately, thus avoiding late manifestations resulting from improper and inadequate treatment. Every syphilitic infant is a potential case of neurosyphilis. Lumbar puncture should not, as a rule, be made before the infant is six months of age because a positive serologic result may not be obtained earlier even though infection has taken place. Results obtained by treating cerebrospinal syphilis in early infancy are encouraging but must be further evaluated before more dependable data are available.

Discussion of the diagnostic phases of the problem of early congenital syphilis has been rather detailed because without adequate diagnostic procedures treatment has limited value. Before dealing with penicillin therapy, it should be pointed out that little information is available on use of penicillin in treating this disease and many phases of treatment have not yet been explored.

Some work has been done in the use of penicillin to prevent transmission of syphilis

from mother to infant in utero. To date, the results look good. These results, however, are limited to a few cases and the follow-up of infants to assure that they were not syphilitic was inadequate. There is no evidence that penicillin permeates the placental barrier because injections of penicillin just prior to delivery did not result in penicillin being recovered from the cord. Thus, an infected fetus may not be benefited by the use of penicillin during the prenatal period. In this respect, penicillin may have the same limitations as other remedies now in use.

The dosage of penicillin used in the treatment of congenital syphilis varies widely but, in general, it has averaged from 10,000 to 50,000 units per kilogram. The time interval and number of injections have been rather constant. As a rule, the three hour interval has been used over an eight day period. Thus, about 64 injections would constitute a single course of therapy. The intramuscular route of administration has been used in infants in a concentration of 5,000 units per one cubic centimeter of saline solution. Studies reveal that excretion of the drug requires injections at not more than three-hour intervals. One clinic has reported good results in infants receiving from 16,000 to 19,000 units per pound of body weight during the eight day period of treatment. This dosage does not appear to be too small because smaller dosage has failed to produce good results. It is quite possible that dosage amounting to as much as 40,000 units or more per pound of body weight may be necessary during the eight day treatment period if desired results are obtained. It seems evident that more experience with penicillin is needed before proper dosage can be recommended for optimal results.

Relapses among infants treated with penicillin are presumably averaging around 10 to 15 per cent or less. This includes both serologic and clinical relapses. By serologic relapse is meant the change from negative to positive in qualitative test or significant elevation in titer in quantitative test. Serologic tests do not reverse quickly in some cases and the only way to measure immediate response to the drug is through

clinical response and quantitative titer serologic determinations. The number of relapses occurring among penicillin treated cases is comparable to or less than the number which occur with arsenic therapy but the penicillin routine is preferred because of the time and effort saved. When failures occur with first series of treatment, good results have been obtained when penicillin is repeated within a short time. This suggests that optimum dosage, or other factor, is yet to be found. When relapses occur, the initial dosage of penicillin should be doubled.

The rapidity with which penicillin in solution deteriorates at room temperature may explain some poor results. In order to maintain the highest potency possible, the solution should be fresh and should be kept refrigerated.

In young infants with severe infections or infants in a debilitated condition, penicillin treatment has produced reactions comparable to those experienced with arsenicals. These cases need special care in order to reduce mortality during treatment. Toxic reactions may or may not be the result of impurities contained in penicillin but are probably Herxheimer reactions. Often a large percentage of cases will have some signs of increased toxemia during early treatment and elevation of temperature and increase in serologic blood titer are common. Occasionally serious reactions appear and collapse and mortality may soon follow. Use of penicillin too vigorously may be a factor in these cases. For this reason, debilitated and toxic cases should be treated with small doses of penicillin preliminary to regular series. It may require weeks to get a child in condition for full dosage penicillin therapy. In all cases, Herxheimer reactions may occur and caution should be exercised. Do not hesitate to reduce the dosage or discontinue the drug because the course can be repeated subsequently. Tolerance of penicillin at a later date would suggest that it is not the drug which is responsible for these reactions but the effect of the drug upon the syphilitic process. Other means of mitigating these reactions may become known

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

OCTOBER, 1945

DON'T LET GEORGE DO IT

A famous psychologist was asked the question: Is it harder to get money from people for charity than to induce them to give time and effort?

His reply was: "It is far harder to induce people to give their time and effort to help the community than it is to induce them to give money. . . . It is hard enough to get either, but when it comes to asking people to roll up their sleeves, attend meetings late at night, get out and actually work, instead of talk, the attitude of most people is: Here's \$5. Let George do it."

Have you, as a citizen and Georgia physician, done anything to stop the enactment of legislation which may take from you and your patients that which you are accustomed to now? Have you studied the new Wagner-Murray bill, Senate Bill 1050? Have you been satisfied to let George do it? Are you aware of the fact that certain individuals and certain groups in this State are working almost constantly to facilitate the passage of this bill?

Busy as you are, please sit down now and write your Representative and Senators in the Congress of the United States for a copy of the bill, at the same time requesting each of them to withhold his support of the proposed measure. By all means, don't let George do it for you. Roll up your sleeves now and "take pen and paper in hand." Remember, it's Senate Bill 1050.

FIFTY YEARS OF X-RAYS

The 50th anniversary of the discovery of x-rays will be the basis of a nationwide educational program during the week of Nov. 5 to 10 to familiarize the public with the importance of radiology in everyday health, Dr. Lewis G. Allen, chairman of the commission on public relations of the American College of Radiology, has announced.

Dr. Allen pointed out that despite the widespread use of x-rays by the medical profession, large sections of the public are completely ignorant of the invaluable aid radiology has been in the prevention, diagnosis and treatment of disease.

"The purpose of the campaign is to increase the public's understanding of the medical specialty of radiology," Dr. Allen said. "We want the public to know that a radiologist is a medical specialist and not a mere technician.

"During *X-ray in Health Week*, we plan to emphasize that x-ray is the instrument of highly skilled physicians and not just a machine which is operated by any engineer or photographer," he said.

The anniversary celebration will be marked by special tribute to Wilhelm Conrad Roentgen, the German physicist, who on Nov. 8, 1895, discovered that radiations existed which had the power to penetrate opaque materials.

It was pointed out that the general public, for the most part, is unaware of Roentgen's connection with x-ray despite the fact that science designates the radiations as "roentgen rays" in honor of the discoverer.

"Roentgen has been neglected by the public because he made no effort to seek the fame and commercial benefits he could have derived from his discovery," Dr. Allen declared. "We hope to awaken in the public a realization that he is one of mankind's greatest benefactors."

The romantic story of the discovery and the development of x-rays in medicine is a familiar one to the medical and other professions, but it is still new to the public.

Few lay persons know that Roentgen found x-rays while conducting an experiment in search of other results. The sensation which was created when the discovery of the rays was announced is still a worthy example of public misconception of a scientific phenomenon.

In the light of the progress made in the practice of medicine with the aid of the x-ray, it is difficult now to believe that a London paper in 1896 recommended that Roentgen and the secret of his discovery be destroyed "to save the world from x-rays."

Fortunately, the medical profession recognized immediately the inestimable value of the new rays which would permit them to peer into a patient's body.

At first limited to examination of the bones of the body and organs which resisted the rays sufficiently to make an image on film, new discoveries soon extended the use of the rays.

Development of fluids opaque to the radiations which could be injected or given orally to a patient made it possible for physicians to use the rays to examine almost any section of the body.

Within a year after its discovery, physicians learned that x-rays had a definite effect upon the tissues of the body and the therapeutic use of the radiations began to develop.

In the comparatively brief period of 50 years, radiology has become one of the essential specialties in the field of medicine.

The campaign prepared by The American College of Radiology is designed to inform the public that x-ray is one of the most important instruments in the war against disease.

Objectives of the campaign are to convince the public that x-ray examination is a guardian of good health, and that the radiologist is a physician especially trained in the use of x-rays for diagnosis or treatment.

Although every modern hospital has its x-ray department, and while physicians, surgeons and dentists depend upon x-ray for diagnosis and prognosis in a large portion of their cases, there are only about 2,000 practicing radiologists in the United States.

The American College of Radiology estimates that at least twice that number are needed to provide adequate health service.

The undersupply of radiologists is blamed on the comparative newness of the specialty, but expansion of educational facilities is expected to increase the supply of physicians trained in radiology.

PHYSICAL MEDICINE

It is the conviction of Dr. George G. Deaver of New York University that no benefaction to American medicine has ever been more timely than that of Bernard M. Baruch when he donated \$1,190,000 to be devoted to teaching and training in the special field of physical medicine.

New York University participated in the gift to the extent of \$250,000 and Dr. Deaver, of the faculty of its college of medicine, is now head of the college's department of physical medicine, which includes its former departments of physical and occupational therapy. The term "physical medicine" as now generally used among doctors, comprehends the whole field of physical restoration and rehabilitation—particularly of fighting men maimed in the war.

"Right now," said Dr. Deaver recently, supplementing a report already made to the Baruch Committee, "the practice of physical medicine within the general domain of medicine, bids fair to take on the character of a profession within the profession. Medicine has come to realize the necessity of treating the patient rather than the disease. And the need of working with him rather than on him. Physical medicine can perhaps best be described as the 'third phase' of medicine, or the phase which, following surgery and hospitalization, is of equal importance with the others—and not infrequently the most important of the three."

Like genius, which the familiar definition describes as an infinite capacity for taking pains, Dr. Deaver describes physical medicine as "an endless capacity for taking pains with the patient who has not only lost the use of part of his body, but has all too often lost faith in himself as well—has reached the state of mind in which he foresees himself as a helpless and hopeless cripple. It is this state of mind and body which physical medicine deems itself obligated to overcome. And it is right now, when the war is sending home its thousands of war casualties, that this branch of medicine has opportunity to make clear that it has moved forward with the demands of war—that it can and will achieve results which, even at the end of the last war, were considered not only impossible but chimerical."

The New York University College of Medicine is working in the field of physical medicine in cooperation with the Army, the Navy, the Air Forces, the Veterans Administration and the National Rehabilitation Council. Dr. Deaver is the author of two short manuals of self-help which are put into the hands of all injured patients, injured veterans of the war particularly. Thousands of them have been distributed in the armed services. They explain in language simple enough to be understood by almost anyone, the basic structure and functions of the human body, and what must and can be done by the patient himself working with his physician, to bring about his own rehabilitation.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

Dr. Deaver declares that when the Baruch Committee was founded, it was not only Mr. Baruch's gift of more than a million, but the timeliness of the creation of the committee that attracted national attention to physical medicine as a branch of the profession up to then insufficiently recognized. He says:

"The average doctor hadn't the time, nor the average hospital the trained men to carry the patient anywhere after his discharge from surgery. And of course at the patient's own home there was virtually no one to give him help or to comprehend that he required helping. Now, the dissemination of knowledge of what is needed for rehabilitation is becoming so wide and general that even in ordinary homes the families and relatives of patients know something of it. Or, at least, there is no longer the general public belief that a badly injured patient is just a perpetual family liability.

"Above all, the patient knows himself what has to be done, and he returns from us determined that he himself, if nobody else, is going to do it. We instill into patients the conviction that they can be restored to working activity because they have already come nearly back to it. And that while they were under our care they have seen others worse off than themselves help bring themselves back."

Dr. Deaver's department at his university was fully established only last December with the consolidation of the two previous departments of physical and occupational therapy and the addition of the newer phases of physical rehabilitation. Its clinic is in Bellevue Hospital. He has fifteen trained therapists and a part-time physician working with him, with five special technicians soon to be added. Infinite patience and the instilling of morale are their two rules above and beyond manipulative and structural mechanics. The number of patients they have brought back to working health is amazing. They have a patient in their charge who has been bed-ridden for fourteen years and is now walking. Another who had spent seven years in hospitals and is now getting about without help although on crutches. Fourth year medical students at the university are required to take Dr. Deaver's course. The university School of Education also requires that certain of its students take his course.

INTERNATIONAL COLLEGE OF SURGEONS MEETING

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7th and 8th, 1945, at the Mayflower Hotel, Washington, D. C. At that time approximately 200 men will receive their Fellowship. A scientific program is arranged for both days. Convocation exercises will be held Friday evening, December 7th, and will be in the Mayflower Auditorium.

WOMAN'S AUXILIARY NEWS

Lt. Col. Francis Parker, head of the pathologic service in the Emory Unit, who served on the board of investigation for the German atrocities and who recently returned from Europe, was the speaker at the first meeting of the year of the Auxiliary to the Fulton County Medical Society. His subject was "Experiences in a German Concentration Camp." Mrs. W. T. Randolph, Winder, president of the Woman's Auxiliary to the Medical Association of Georgia, also spoke. The meeting was followed by luncheon served by the following committee: Mrs. Clifford Eskey, chairman; Mesdames D. T. Heyser, Linton T. Smith, Joseph Yampolsky, George Fuller, George Wagnon, Edgar Shanks and John Funke.

* * *

Mrs. Luther H. Kice, chairman of the Committee on Legislation for the Auxiliary to the American Medical Association, reminds us that following the traditional custom as keepers of the home, it has been pointed out that European women lost no time in sweeping off their hearthstones, although often little else remained. While our homes escaped the pathway of war's destruction, American women are confronted with no mean task in sweeping from their hearthstones forces which are threatening the very foundation of all that is American. State auxiliaries are reminded to seek guidance from their advisory councils and respective medical societies in all legislative matters. She calls attention to pending legislation of interest to all Auxiliary members:

1. The Burton-Hill Hospital Bill (S 191), upon which hearings may be held this fall, is in the Senate Committee on Finances.
2. The Ellender Bill (S 637) concerning the release of persons from active military service in order to aid in making possible the education and training of physicians and dentists to meet essential needs. It has been referred to the Senate Committee on Military Affairs.
3. The new Wagner-Murray-Dingell Bill (S 1050) contains 185 pages to the old bill's 90 pages. While substantially the same as the former one, it has many new additions. Analysis of same demands the serious consideration of every American citizen. Hearings are expected this fall. Referred to Senate Committee on Finance.
4. All legislative measures relating to the World War veterans.

The most important point in Mrs. Kice's report was that we emphasize, whenever socialized medicine is discussed, the fact that preventive medicine—not mere spending of money—is of importance. There is no such thing as free medicine—you pay for it in taxes. Make argument specific rather than general, for remember a person is always more interested in what concerns him personally.

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cather, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALnut 8911; residence, JACKson 7979.

OFFICIAL CALL to the BUSINESS CONFERENCES of the GEORGIA NURSING GROUPS

The 39th Annual Session of Georgia State Nurses' Association, and her Private Duty Section; the 19th Annual Session Georgia State League of Nursing Education; the 20th Annual Session, Georgia State Organization for Public Health Nursing; the 2nd Annual Session of the Georgia Association of Industrial Nurses, and the 5th Annual Session of the State Nursing Council for War Service will be held November 5-6, 1945, at the Henry Grady Hotel, and the Academy of Medicine in Atlanta.

*Message from Lillian O. Nelson, R.N.,
President, G. S. N. A.*

The president of the G. S. N. A. joins all presidents of state nursing groups in sounding the gong for attendance at the annual business sessions—November 5-6, 1945, at Atlanta.

Meeting together to discuss immediate plans as well as plans for the future is our American way, our democratic way, the way of life for which we have fought so long and hard. At that time groups interested in the welfare and health of our nation are meeting to make plans of economic and social significance which affect all peoples. Nurses have a major part in this total program.

Following is a timely and recent statement of Miss Lucile Petry:

"If we nurses, with the help of others, can plan to meet an analyzed need in wartime, we should be able to make an effective plan for times of peace. It is now that we must dig the trenches and lay the foundation for the nursing we want to give our communities in the post-war world. This work is the investment that will pay substantial dividends in the future. We like to think that progress is the watchword of the nursing profession. It is up to us to give that word full meaning. We can do it if we begin today to lay our plans. We are in a strategic position—we have a toe-hold we will never regain if we do not use it to full advantage in forging ahead."

The great need for nursing service in civilian programs makes it extremely necessary for nursing groups to get together and review the *Facts About Nursing* in 1945, also to plan ways and means for better programs for nursing education and distribution of nursing service. Counseling and placement service will again be studied. The following business sessions have been outlined:

MONDAY, NOVEMBER 5, 1945

3:00 P.M.-5:00 P.M.—Executive Board G. S. N. A., State Nursing Headquarters, 131 Forrest Avenue, N. E.

7:00 P.M.—Executive Committee, State Nursing Council for War Service, Henry Grady Hotel.

8:00 P.M.—State Nursing Council for War Service, Business Session, Henry Grady Hotel.

TUESDAY, NOVEMBER 6, 1945

9:00 A.M.-10:30 A.M.—Business Sessions: G. L. N. E.; G. S. O. P. H. N.; P. D. Section G. S. N. A.; G. A. I. N.; Academy of Medicine, 875 West Peachtree St., N. E.

10:30 A.M.-12:00 Noon—Business Session G. S. N. A., Academy of Medicine.

12:45 P.M.-2:15 P.M.—Luncheon, Biltmore Hotel (open to all). Make reservations now at State Nursing Headquarters.

2:30 P.M.-3:30 P.M.—Business Sessions: G. L. N. E.; G. S. O. P. H. N.; P. D. Section G. S. N. A.; G. A. I. N.

3:30 P.M.-5:15 P.M.—Continued Business Session, G. S. N. A.

5:15 P.M.-6:15 P.M.—New Executive Board Meetings of State Nursing Groups.

7:30 P.M.—New G. S. N. A. Executive Board Meeting, State Nursing Headquarters.

Local Arrangements Committee

Chairman—Durice D. Hanson, telephone WALnut 8911 or JACKson 7979.

Co-Chairman—Lucy Mace, VERNON 7711 or VERNON 9590.

Registration—Mrs. Elizabeth Dixon, Chairman, JACKson 1321.

Publicity—Durice D. Hanson, Chairman, WALnut 8911 or JACKson 7979.

American Journal of Nursing—Agnes McGinley, Chairman, Athens.

Public Health Nursing—Eunice Chapman, Chairman, Winder.

EARLY CONGENITAL SYPHILIS

(Continued from page 203)

but at present reduced dosage is the only suggestion offered.

Every infant should receive the best pediatric supportive care possible during treatment because such measures often make the difference between failure and success.

Despite some relapses, the clinical response to penicillin is very encouraging. Cutaneous and mucous membrane lesions usually heal during or within a week following initial treatments. Rhinitis or snuffles is more resistant, as when arsenic is used, and may require several months to respond. Darkfield lesions that are positive before treatment may become negative within 8 hours following first treatment. Roentgenographic evidence of bone disease may remain for several months or longer even when the treatment is adequate. With sufficient treatment positive spinal fluid findings may fade within a few weeks or months. Blood serologic test may become negative after some months have elapsed. Quantitative test will show a decline in titer within a few weeks or months. The failure of a titer to decrease is not evidence of activity of the syphilitic process but a rising titer is evidence that additional therapy is needed.

Penicillin promises to be a very effective therapeutic agent in the treatment of congenital syphilis although the optimum time dosage relationship is not yet known. Compared with results obtained with arsenicals, penicillin appears to be as, or more, effective in treatment of congenital syphilis and it offers advantages in the reduction of time and effort required for adequate treatment of cases.

To briefly summarize:

1. Nothing is more important than early and accurate diagnosis in congenital syphilis and the quantitative test can be very valuable in making correct diagnosis and checking progress of treatment.

2. Before ruling out syphilis in an infant born of a syphilitic mother, it is wise to: study disease in mother; make intensive clinical appraisal, make serologic tests; use darkfield technic whenever possible; and employ x-ray in diagnosis.

3. Every infant should be thoroughly studied for evidence of neurosyphilis and a lumbar puncture should be done several months after completion of routine treatment and before dismissal of patient.

4. In penicillin therapy, dosage varies widely but the three hour interval over an eight day period is generally used. Relapses occur in penicillin treatment which would indicate that optimum dosage is yet to be found.

5. When toxic reactions occur, small dosage over a period of time is recommended before full dosage treatment is inaugurated.

6. Penicillin promises to be very effective in treating congenital syphilis and much time and effort are saved in the treatment process.

WAR BONDS

Show your appreciation of the recent peace by buying Victory War Bonds.

ORTHOPEDIC FOOTWEAR CLINIC

An orthopedic clinic has been opened at the Boston Quartermaster Depot to supply scientifically designed lasts for shoes that will be specially built for soldiers who have suffered foot injuries in line of duty. Details of the Clinic were worked out jointly by the Office of The Quartermaster General and the Office of The Surgeon General which has assigned an orthopedic surgeon, Major Saul S. Steinbergh, M.C., to the Clinic.

A recent "spot check" of general and regional hospitals showed that about a thousand patients are in need of special footwear and many of these will require orthopedic shoes as long as they live, according to Colonel Leonard T. Peterson, Chief of the Orthopedic Branch, Office of The Surgeon General.

Requirements from which the special shoe lasts must be made are very exacting. A newly invented cast making machine, which assures a scientifically accurate mold, has been installed at the Clinic and courses are now being given in its operation. Attending these courses are enlisted orthopedic mechanics from ten hospitals where similar machines will be installed. These hospitals are Lawson General at Atlanta, Ga., Vaughan General at Hines, Ill., McCloskey General at Temple, Tex., Walter Reed General at Washington, D. C., Billings General at Ft. Benjamin Harrison, Ind., Bushnell General at Brigham City, Utah, Dibble General at Menlo Park, Calif., Madigan General at Tacoma, Wash., and the U. S. Hospital Centers at Camp Edwards, Mass., and Camp Carson, Colo.

Lasts for orthopedic shoes will not be made until foot injuries have healed sufficiently so measurements will not change. The patient will then be sent to have a cast made at the nearest hospital which has a casting machine. Measurements can be completed within an hour. After the patient is discharged from the Army his special shoe last will be available for future use.

NEWS ITEMS

The Fulton County Medical Society held its regular dinner meeting at the Academy of Medicine, Atlanta, September 6. Scientific program: "Case Report From Emory University Hospital on the Surgical Treatment of a Certain Phase of Congenital Heart Disease," Dr. Chas. S. Ward and Dr. C. J. Williams; "Magnetic Removal of Foreign Bodies From the Food and Air Passages." Lantern Slides. Dr. Murdock S. Eguen; "Problem of the Rickettsial Infection in Georgia," Dr. C. Dan Bowdoin. Discussion: Drs. A. C. Gilliam and Paul B. Beeson.

Dr. Scott L. Tarplee, Atlanta, announces the opening of his offices for the practice of internal medicine, suite 512-520 Grand Theatre Building, Atlanta.

Dr. F. C. Holden, Atlanta, who has been ill, is returning to the general practice of medicine and surgery. His new office will be located at 104 Ponce de Leon Avenue, N.E., Atlanta.

According to the *Atlanta Constitution* "the arrival home, after more than two action-packed years of foreign service, of Atlanta's own Emory hospital unit, highlights the return of many much-missed medical men to civilian life.

"The Emory Unit's record in this war is just as splendid as its rich history indicated it would be. Its services during the invasion of both Africa and France was gruelling beyond the call of duty and the fact that, of the 30,000 casualties treated, the death rate was less than one per cent, is ample evidence of its skill and proficiency.

"Atlanta welcomes the return of these heroes all the more because they are so badly needed here at home where their overworked colleagues have been hard-pressed to administer adequately to the community's health requirements.

"We are gratified to note, incidentally, that the Army has announced its intention of hurrying the release of as many doctors and nurses as possible with a new discharge system which promises to return 30,000 doctors, 10,000 dentists and 40,000 nurses to civilian life by next July 1.

"The relatively few doctors who have remained on the homefront have done a magnificent job but additional aid will be needed this winter if many communities are to escape the ravages of cold-weather diseases."

Dr. Courtney C. Brooks, recently discharged from the U. S. Army, has located at Cumming to practice medicine.

Emory University School of Medicine, Atlanta, has announced a number of changes in its faculty. Chief among those assigned to new faculty posts is Dr. Russell Oppenheimer, nationally known medical educator, who retired as dean of the medical school in June. He has returned, after a three-month leave, to take over his duties as full-time professor of clinical medicine.

After three years of Army service, Dr. Francis P. Parker has come back to Emory as assistant professor of pathology, a position which he held prior to entering the service.

Dr. Osler A. Abbott, formerly connected with Washington University School of Medicine, St. Louis, has

begun his association with Emory as full-time associate in surgery. His special interest is thoracic surgery.

Dr. R. Hugh Wood, Atlanta physician and Army veteran, will soon assume his duties as full-time professor of medicine in charge of the graduate and post-graduate program of the school of medicine at Emory Hospital.

Dr. Sidney C. Madden came to Emory from the University of Rochester School of Medicine and Dentistry, Rochester, N. Y., and will be professor and chairman of the department of pathology.

Dr. and Mrs. Champ H. Holmes, formerly of Atlanta, are now residing at their ocean-front home, Atlantic Beach, Fla.

Dr. J. A. Hembree, Pearson, announces the opening of his office in the Sibbett Building, Douglas.

The Seventh District Medical Society meeting was held at the Coosa Country Club, Rome, September 26. The Society and members of the Woman's Auxiliary were guests of the Floyd County Medical Society. Dr. Holmes Cheney, president of the Floyd County Medical Society, "Address of Welcome." Titles of papers on the scientific program were: "The Present-Day Status of Syphilis Therapy," Dr. Forrest C. Hunter, U. S. P. H. S., Augusta; discussion led by Major Harold Price, M. C., Battey General Hospital, Rome, and Dr. R. N. Little, Summerville; "Occupational Dermatitis" illustrated with Kodachrome slides, Dr. Clarence Shaw, Chattanooga, Tenn.; discussion led by Major Harold Price, M. C., and Dr. William Harbin, both of Rome; "Pruritus Ani," Dr. Marion C. Pruitt, Atlanta; discussion led by Dr. William Hall, Calhoun, and Dr. R. W. Fowler, Marietta; "Conservative Surgical Approach of Upper Urinary Tract Pathology," Major C. H. Barnwell, M. C., Battey General Hospital, Rome; discussion led by Dr. Truman Whitfield, Dalton, and Dr. John Garrard, Rome. Officers: President, Dr. F. H. Simonton, Chickamauga; President-elect, Dr. W. C. Mitchell, Smyrna, and Secretary-Treasurer, Dr. Inman Smith, Rome.

Officers of the Woman's Auxiliary: District Manager, Mrs. W. C. Mitchell, Smyrna; and Secretary, Mrs. Wilbur Hall, Calhoun. Dr. Forrest C. Hunter, U. S. P. H. S., Augusta, was guest speaker. Mrs. William Harbin, Rome, welcomed the guests and Mrs. Ralph Fowler, Marietta, made the response.

Dr. C. Stedman Glisson, Jr., Atlanta, having returned from active service with the United States Army Medical Corps, announces the re-opening of his offices, suite 407 Medical Arts Building, Atlanta. Practice limited to obstetrics and gynecology.

Dr. Homer Head, Dahlonge, announces the removal of his office to Monroe where he will continue to practice medicine. His many friends at Dahlonge wish for him every success.

The Fulton County Medical Society, Atlanta, announced plans to aid physicians returning to Atlanta from the armed forces. Dr. Edgar H. Greene is chairman of the committee to help physicians re-establish their practice or, if they have never practiced, find a desirable location in Atlanta. Other members are Dr. W. P. Nicolson, Jr., and Dr. W. C. Warren, Jr. An information bureau will

be established at the Academy of Medicine, 875 West Peachtree Street, N. E., to furnish data about possible office locations, partners, assistants, hospital privileges and other matters.

The committee will help physicians get their former patients and also endeavor to see that those who did contract practice continue to work for the same companies. In placing men who have never practiced, the committee is working with the War Manpower Commission Office of Procurement and Assignment.

Physicians in the armed forces have been sent a letter explaining the work of the Fulton County Medical Society committee. Members of the society have received a questionnaire which will help in placing the returning physicians.

The members are being asked if they can share their office space during hours they do not use it. "It's almost impossible to secure new space, so that many members returning will have nowhere to see their patients unless some such plan can be worked out," the letter explained.

A grievance committee also has been appointed to hear any complaints from returning veterans in the profession.

OBITUARY

Dr. Craig Barrow, aged 69, of Savannah, distinguished in the field of medicine and in civic work, died Aug. 31, 1945. He was graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, in 1900. His services to his community are best portrayed in an editorial in the *Savannah Press* of Aug. 31, 1945, which follows:

"A life of service to his fellowmen in all walks of life closed this morning when Dr. Craig Barrow succumbed unexpectedly after an illness of fleeting duration. There are many to remember his ministrations as physician and to recall him during the years to come with affectionate regard for his qualities of friendship and his social graces.

"During the years that he practiced his profession in Savannah Dr. Barrow occupied a high place in the estimation of his colleagues and patients. Outstanding in the professional field was the hospital work with which he had been identified for many years. At the time of his death he was chief surgeon of the Central of Georgia Railway and as such headed the Central of Georgia Hospital. This magnificent institution was founded during his tenure as chief surgeon and grew and developed under his leadership. It was the center of his professional and personal attention and enthusiasm and stands as an enduring monument to him. For many years, more than a third of a century, Dr. Barrow gave of his time and skill to another hospital, too, the Georgia Infirmary. This more than a century old institution for colored people was headed for several years by Dr. Barrow as president, from which office he retired in July of 1940. On the Georgia Infirmary, its problems and its services to the colored population Dr. Barrow expended much time and he relinquished his activities there only when the passing years made it advisable for him to have fewer responsibilities.

"As engrossed as he was in his medical work, both

through his office and in the hospitals, Dr. Barrow found time for other activities. Some years ago he served as an alderman of the City of Savannah and with characteristic thoroughness laid the foundations for the milk sanitation code. He had served his alma mater, the University of Georgia, as president of the alumni, and Georgians knew him also in connection with the preservation of the history of the state, particularly as governor of the Society of the Colonial Wars in the State of Georgia.

"It is such men as Dr. Barrow was who by their works and interests make the world a better place in which to live. Many, young and old, will sorely miss him."

Dr. Julian H. Chandler, aged 66, prominent physician of Swainsboro, died Aug. 20, 1945. He was a native of Burke County, and the son of the late Dr. William Hamilton Chandler and Norma Wimberly Chandler. Dr. Chandler was graduated from the University of Georgia School of Medicine, Augusta, in 1900. He was a member of the Emanuel County Medical Society, the Medical Association of Georgia, the First Baptist Church, and was a Shriner. He was a beloved citizen, identified with the civic and religious affairs of his city and county. He is survived by his wife, Mrs. Julia Pugh Chandler, of Swainsboro, a daughter, Mrs. James Peterson, of Ailey; five sisters, and three brothers. Funeral services were held from the Swainsboro Mortuary, conducted by his pastor, Rev. Byron Kennerly, and Rev. J. A. Reiser, of Metter, a former pastor.

Dr. Bernard Singleton Gostin, aged 65, of Macon, died at his home Aug. 28, 1945. He was born at Oglethorpe, the son of Dr. George Pierce Gostin and Mrs. Rosa Jessup Gostin. He was graduated from the College of Physicians and Surgeons of Baltimore, in 1903. Dr. Gostin had practiced medicine in Macon for 30 years. He was a member of the Bibb County Medical Society and the Medical Association of Georgia. Surviving are his wife, Mrs. Katherine Elizabeth Dawson Gostin, a son, Belgrave F. Gostin; two daughters, Mrs. Sidney T. France and Miss Rosita Jessup Gostin, all of Macon; a sister, Mrs. Lloyd E. Meilenz, Macon; a brother, Ernest Lamar Gostin, Macon; and two grandchildren, Bernard H. France and Sylvia S. France, Macon. Funeral services were held at the chapel of Hart's Mortuary, with Dr. Silas Johnson officiating. Burial was in Macon Mausoleum.

Dr. Sandy Byars Harrell, aged 77, Macon, died at his home Aug. 23, 1945. He was graduated from the University of Nashville Medical Department, Nashville, Tenn., in 1902. Even though he was unable to practice medicine as in the past, he kept his office open due to the shortage of physicians and was valuable in the medical field almost up to the time of his death. He is survived by his wife, Mrs. Zella Matthews Harrell. Funeral services were held from the chapel of Hart's Funeral Home, Macon, Rev. Clyde Smith and Rev. R. W. Phillips officiating. Burial was in the cemetery of the Bethlehem Methodist Church, Bethlehem.

Dr. Agnew Hodge Hilsman, aged 69, widely loved Albany physician, died at his home Aug. 23, 1945. He was the son of the late Dr. and Mrs. Palaemon L. Hilsman. Dr. Hilsman graduated from the Cornell University Medical College, New York City, in 1899. He was the third in a family line of four physicians. Greatly beloved by the people of his community, a successful physician and skilled surgeon, he will be remembered as one who gave his all to the profession which he honored. No physician loved his high calling more devotedly, or served humanity more unselfishly. He was a member of the Dougherty County Medical Society, the Medical Association of Georgia and St. Paul's Episcopal Church. Survivors are his wife, Mrs. Lucy Brumby Hilsman; three sons, Captain P. L. Hilsman, Army Medical Corps; Agnew Hilsman, Jr., Atlanta, and Lt. Col. Thomas B. Hilsman, stationed in Europe; a sister, Mrs. John A. Davis, and a brother, Youel G. Hilsman, both of Albany. Three grandchildren, Agnew H. Hilsman III, Lucy Hilsman and Palaemon Hilsman. Funeral services were held from St. Paul's Episcopal Church, with the Rt. Rev. John Moore Walker, Bishop of Atlanta, and the Rev. C. E. Crusoe of Tifton, officiating. Burial was in Oakview Cemetery.

Dr. Horace Gordon Huey, aged 54, prominent physician and surgeon of Homerville, died at his home Aug. 25, 1945. He was a native of Pike County, Alabama. He graduated from the Chicago College of Medicine and Surgery, Chicago, in 1915, and did extensive post-graduate work at Johns Hopkins, Harvard University and other medical centers. Dr. Huey moved to Homerville from New Brockton, Ala., in 1918. The first county health work in Clinch County was begun by his efforts. He was a member of the Ware County Medical Society, the Medical Association of Georgia and the American Medical Association. He was a steward and liberal supporter of the Homerville Methodist Church, of which he was long a member.

Surviving are his wife, Mrs. Janie Owen Huey; a daughter, Mrs. D. B. Terry; a son, George O. Huey; three grandchildren, Dan Terry, Sandra and H. G. Huey, Jr., of Homerville; one sister and four brothers. Funeral services were held at the Homerville Methodist Church, with Dr. Leonard H. Cochran, Rev. T. H. Tinsley and Dr. B. G. Osipoff officiating. Burial was at New Brockton, Ala.

Dr. George Robert McAliley, aged 66, Atlanta pediatrician, died at the Walter Reed Hospital, Washington, D. C., Sept. 15, 1945. He was a graduate of Johns Hopkins University School of Medicine, Baltimore, in 1912. An Atlanta physician for more than 30 years, Dr. McAliley was a medical teacher, author of a medical book, and founder of a baby clinic. Dr. McAliley served as a captain in the first war, being stationed as a medical officer at Camp Gordon. Active in medical and fraternal circles, he was a Mason and Shriner, a Rotarian, a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southern Medical Association, the American Medical Association, and a fellow of the American Academy of Pediatrics.

Surviving is his stepdaughter, Miss Louise Cramer,

of Atlanta. Funeral services were held at Spring Hill, with Dr. Robert W. Burns officiating. Burial was in West View Cemetery.

Dr. William Walter Young, aged 55, of Atlanta, professor of psychiatry and neurology at Emory University School of Medicine, died at his residence Sept. 7, 1945. Dr. Young was born at Alexandria, Va., son of the late Rev. and Mrs. William J. Young. He graduated from the Johns Hopkins University School of Medicine, Baltimore, in 1913. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Psychiatric Association, the American Medical Association, the Southern Medical Association and the First Methodist Church of Atlanta. He is survived by his wife, Mrs. Kirby Willingham Young, and one daughter, Miss Mary Kirby Young. Funeral services were held at Spring Hill, with Dr. Pierce Harris officiating. Burial was in West View Cemetery.

PREVENTABLE ILLNESS AND DEATHS CAUSED BY DISREGARD OF SANITARY PRINCIPLES

Each year thousands of persons become ill in this country and some persons die because of disease needlessly spread by contaminated drinking water and various food products, including milk.

Latest U. S. Public Health Service figures on disease transmitted by water and a number of different foods, show that during 1943 there were 389 outbreaks, resulting in 23, 665 cases of illness and 56 deaths.

This considerable amount of preventable illness and mortality, says the Public Health Service, was caused by disregard of fundamental sanitary principles. The Public Health Service report concerns only outbreaks, and therefore does not include all cases of diseases transmitted by water and food products.

Water from public, private, or school wells, surface supplies, and irrigation ditches was responsible for 26 outbreaks, 5,612 cases of illness, and 15 deaths. Principal diseases spread by impure water were gastroenteritis and typhoid fever. Chief causes of the water-borne epidemics were lack of or improper chlorination and inadequate protection from surface drainage and seepage from sewage.

Contaminated sweet milk, ice cream, cheese, milk shakes, and buttermilk caused 40 outbreaks, 1,590 cases of illness, and 7 deaths. Improper cleansing of utensils, bulk milk contamination, and disease carriers were important causes of milk contamination. Diseases caused by such contaminated products included diphtheria, food poisoning, gastroenteritis, scarlet fever, and typhoid fever.

A wide variety of contaminated foods caused 285 outbreaks, 13,938 illnesses, and 33 deaths. The food-borne outbreaks included cases of dysentery, chemical or bacterial food poisoning, gastroenteritis, typhoid fever, paratyphoid fever, scarlet fever, trichinosis, and botulism. Some of the causes of food contamination reported by the Public Health Service included improperly processed home canned foods, lack of or improper refrigeration, infected food handlers, careless food handling, and possible infection by flies and rodents.

FOUR SPECIALISTS REPORT ON 2-YEAR STUDY OF 'ATHLETE'S FOOT'

The war and marching soldiers have given fresh significance to the prevention and treatment of infections of the feet, especially "athlete's foot," which is caused by one of the many varieties of higher fungi related to the common molds.

Following the discovery that approximately 8 per cent of all hospital admissions in the Army and Navy were for skin diseases and that athlete's foot ranked second on the list, various government agencies and the Council on Pharmacy and Chemistry of the American Medical Association supplied funds and facilities for the study of scientific evidence for the prevention and treatment of diseases of the feet.

Subsequently, the Council enlisted the help of four authorities in the field of dermatology. They were: Fred D. Weidman, M.D., professor of dermatologic research, University of Pennsylvania School of Medicine, Philadelphia; Chester W. Emmons, Ph.D., principal mycologist, United States Public Health Service, National Institute of Health, Bethesda, Md.; Joseph G. Hopkins, M.D., professor of dermatology, Columbia University College of Physicians and Surgeons, and George M. Lewis, M.D., associate professor of clinical medicine, Cornell University Medical School, New York.

Their study, which required two years, is published in the July 14 issue of *The Journal of the American Medical Association*.

The disease, commonly known as athlete's foot, is carried between the toes of a large percentage of those who consider themselves perfectly healthy. It is spread chiefly by walking on moist, infected floors of bathrooms, gymnasiums and golf clubs.

"The treacherous ground of self treatment has been thoroughly explored by us," the four authors said. "Although there appears to be a consensus among dermatologists against self treatment, it remains that a large section of the public will still treat itself. . . ."

While the authors claim that few individuals are capable of even approximating an evaluation of their diseases, even athlete's foot, the public is bound to practice self treatment of one or another kind. For this reason, the specialists offer this advice to those who are prone to treat their own cases of athlete's foot at home:

1. Keep the feet clean and dry, with special attention to places between the toes. Dry these carefully but not so hard as to irritate the skin.

2. Air shoes and socks when not in use.

3. Under special conditions, keep the feet elevated when at rest.

4. Shoes should be selected that are as light and well aerated as is compatible with working conditions.

5. A dusting powder consisting of 10 per cent boric acid in powdered talc should be dusted on the feet and between the toes every night and morning.

In addition, the authors made these suggestions in treatment:

"Only the mild lesions (sores) that occur between the toes should be treated by the patient himself; that is, where the lesions exhibit only scaliness and perhaps mild redness and fissuring. Considerable redness, moisture, pustule formation or pain call for the attention of the physician and the physician only."

JOSEPH ROSIN, PHARMACEUTICAL CHEMIST, WINS REMINGTON MEDAL FOR 1945

Contributions to scientific pharmacy and the development of drug standards have won the Remington Medal for Joseph Rosin, pharmaceutical chemist of Plainfield, N. J., the New York branch of the American Pharmaceutical Association has announced.

Mr. Rosin becomes the twenty-fourth Remington medalist, the honor being conferred each year upon the person whose work during the preceding year, or culminating over a period of years, is judged most important to American pharmacy. The gold medal commemorates Joseph P. Remington, nineteenth century pharmacist who made many contributions to research, education and pharmaceutical literature.

In naming Mr. Rosin to receive the medal, the Committee on Award cited his work as "the foremost American authority on chemical reagents" and stated that the Pharmacopoeia and National Formulary "are today more indebted to Mr. Rosin for the excellent quality of their chemical standards than to any other person."

He first participated in this important work in 1910, and for the past fifteen years has been a member of the U. S. P. Committee of Revision and several subcommittees. Mr. Rosin has been largely responsible for drawing the official requirements for such drugs as the sulfonamides and vitamins.

SCHERING CORPORATION APPOINTS VETERAN AS SOUTHERN DISTRICT SUPERVISOR

Perry L. Stucker, after nearly three years in the Army, becomes southern district supervisor for the Schering Corporation, manufacturers of endocrine and pharmaceutical preparations. Mr. Stucker will supervise Schering service in Oklahoma, Texas, Louisiana, Alabama, Georgia and Florida. He will be located in Atlanta.

Expert Clinical Interpretation of Chest X-Ray Films

CHAMP H. HOLMES, M. D.

P. O. Box 365

Atlantic Beach, Florida

HOSPITAL — PHYSICIAN LABORATORY SUPPLIES AND EQUIPMENT

★

SURGICAL SELLING CO.

Phone WALnut 5585

139 Forrest Ave., N. E.

ATLANTA — — — — GEORGIA

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, November, 1945

Number 11

PROBLEMS IN THE TREATMENT OF RHEUMATIC HEART DISEASE

JOSEPH YAMPOLSKY, M.D.

Atlanta

The treatment of rheumatic heart disease in children depends not only upon actual medical treatment, but also upon the evaluation of the different phases of this condition. The difficulties experienced in early diagnosis are of such character that many times we do not see these patients until definite valvular disease has been established. For that reason it is of the utmost importance that we evaluate early manifestations of active rheumatic infections. This is especially true when we try to make a decision as to the activity or inactivity of rheumatic disease. One must always impress the family of the patient that one is dealing with a condition which will require prolonged treatment as well as prolonged rest in bed.

The acute attack manifests itself not only in polyarthrititis and fever, but many times in an acute form of carditis. In this condition rest is of great importance. Simple treatment, along with analgesics, sometimes suffices. We have no difficulty in keeping the patient in bed when he is acutely ill but as soon as he begins to feel less pain, and is fever free, he becomes a greater problem to the physician.

While the salicylates are of definite benefit in the acute manifestations of the disease, there certainly seems to be no specific of any kind for the heart disease. Rest is one of the most important methods of treating any manifestation of heart disease, and should be employed at the earli-

est moment. We know that while the rheumatic lesions in the joint heal, lesions of the cardiac tissues do not heal readily, and if they do they do so only with formation of local fibrosis. For that reason, it must be remembered that patients in this phase must be kept as quiet as possible. Even a small increase of as little as five to ten beats a minute will cause a marked impact upon the heart valves and rest must be insisted on, certainly during the acute period of the disease.

If there are definite signs of development of carditis, the child must be not only kept quiet but must be fed, given bed baths and even be lifted on the bed pan. If restless, many sedatives, such as phenobarbital $\frac{1}{2}$ grain, or aspirin 5 to 10 grains are given. In carditis rest is much more important, and codeine $\frac{1}{4}$ to $\frac{1}{2}$ grain may be given by mouth a day, or as often as necessary.

After the inflammation has subsided it is of the greatest importance that three to six weeks' bed rest should be the routine treatment. We have very few diagnostic means for the determination that the inflammation has subsided. The most important method is that of measuring the sedimentation rate. A high sedimentation rate certainly means that the process is very active, but if the rate goes down we may presume that the activity has subsided. When the sedimentation rate is normal, three to six weeks of rest in bed is advisable and favorable.

In the opinion of Taussig and others¹ the question whether salicylates are indicated in the treatment of rheumatic carditis is certainly questionable, as there is no evidence as yet to support the idea that salicylates alter this condition in any way, but we do know that they reduce inflammation in the joints as well as control the pain. So when either one of these condi-

From the Department of Pediatrics, Emory University School of Medicine, and the Children's Wards of Grady Hospital, Atlanta.

Read before the Medical Association of Georgia, Savannah Session, 1944.

tions is present, salicylates are indeed indicated. As to the dosage of salicylates they can be given in the form of simple aspirin or acetylsalicylic acid. The drug may be given in doses from $\frac{1}{2}$ to 1 grain per pound of body weight a day. Of course, it is always advisable to combine the salicylates with sodium bicarbonate.

It is of the utmost importance to withdraw the salicylates gradually after the administration of large doses. It is best to wait at least two weeks after the medicine has been completely stopped before one may know whether the rheumatic process has subsided or whether the pain has not merely been relieved by salicylates.

Another preparation which has been my privilege to use in the treatment of rheumatic joints has been amidopyrine. The most important advantage in the use of this drug is its potency, as it is usually six times that of salicylates. However, it is to be remembered that certain unforeseen symptoms may manifest themselves with the use of amidopyrine, such as agranulocytic angina. It is important that a white blood count be done on all these patients, and when there is a decrease of polymorphonuclear neutrophils this drug must be withdrawn immediately. Of course, with the use of this drug the patients must be kept for some weeks in bed, such as is the case when salicylates are used. When the acute phase has subsided we are faced with another problem. Is it possible to use some drug in some manner so as to avoid further injury to the heart and its valves? If some drug can be used in a prophylactic manner for several weeks or months, is it possible to keep the heart and its valves from further disturbance?

Since the advent of sulfanilamide this drug has been used as a prophylactic by Hansen, Platou and Dwan². In their experience sulfanilamide, or a similar drug, was administered to 53 children for a total of 78 season-cases to determine their value in preventing the occurrence of active rheumatic cycles. These results have been compared with those observed in 32 control children followed for a total of 46 season-cases.

In their report they found that only 2 of the 53 children treated with sulfonamide compounds experienced a rheumatic flare-up, and in 1 this occurred within six days after the use of the drug was begun. Seventeen of the 32 children in the control group had a total of 21 rheumatic recrudescences. Eight of these recurrences were considered moderately severe, 7 were mild and in 6 of the subjects attacks of chorea were noted. In addition, the treated patients seemed favorably affected as regards the trend in degree of cardiac involvement, size of the heart and functional classification. No difference was noted in the number of infections of the upper respiratory tract in the two groups, but the treated patients seemed to be in better condition. There were hardly any toxic manifestations encountered. There was no evidence that the sulfonamide compounds produced changes in the electrocardiograms which may be interpreted as being deleterious. They conclude that although the incidence of rheumatic recrudescences in the control group may be higher than usual, it is due primarily to age and social status of the patients; and secondarily, patients with the mildest attacks were put at complete rest, even though the symptoms were very mild. They believe that these results should be studied further.

Pennoyer and Hansen, in discussing the prophylactic approaches in preventing rheumatic recrudescences, lay special emphasis on the continuous use of sulfonamides; that is, doses for children between 15 and 20 grains daily, to maintain a blood level of 2 to 3 mg. per cent. The purpose in doing this is to reduce theoretically the incidence of streptococcic infections and thereby the rheumatic flare-ups.

They preferred the use of sulfanilamide because it is effective in streptococcic infections, is better tolerated by children, and does not cause the genito-urinary symptoms induced by sulfadiazine. The blood is checked from time-to-time, and only mild complications occurred in their series. They think it is best to take this drug all the year round.

Slocumb and Polley have reviewed the

literature on sulfonamides as prophylaxis in the treatment of rheumatic fever. The number of recurrences of acute rheumatic fever, or chorea, during treatment is about 1.6 per cent as compared with 10 to 45 per cent among the controls.

They agree that sulfanilamide is contraindicated in acute rheumatic fever and is of no value in preventing a flare-up of rheumatic fever if treatment is started after the hemolytic streptococcal sore throat has developed. Small doses, however, do help in preventing recurrent sore throats and recurrent attacks of rheumatic fever. The beneficial effects of this drug are present only during the time that it is being taken. Occasionally toxic reactions occur, but usually they are not of serious nature.

Kuttner reviews the study of the use of sulfanilamide in many clinics. The majority of reports seem to be in striking accord. They all agree that this type of prophylaxis is effective in preventing rheumatic subjects from contracting streptococcal upper respiratory tract infections, and that individuals so protected escape rheumatic relapses.

The author's own observations are interesting. In the control group 30 of 54 children contracted streptococcal pharyngitis during the winter, while in the sulfanilamide group only 1 child out of 54 contracted the pharyngitis due to streptococcus type XV, and she escaped rheumatic sequelae. A great number of these children showed no signs of hypersensitivity when sulfanilamide was resumed after a rest during the summer.

Prophylactic sulfadiazine has also been used on a large scale by the Army and Navy Air Forces. Coburn reported only mild toxic manifestations in about 0.5 per cent and severe in only 0.01 per cent. No renal complications were observed.

Since the incidence of toxic reactions is less with sulfadiazine than with sulfanilamide, and since it is possible to maintain an adequate blood level with a single daily dose, sulfadiazine is Kuttner's drug of choice for sulfonamide prophylaxis.

There are naturally many disadvantages to the use of sulfadiazine because it may produce sulfa-resistant strains of strepto-

cocci. Also it is known that these patients may be susceptible to infection when the drug is withdrawn.

The administration of a drug of this kind may sometimes interfere with normal growth and development, and may exert a delayed deleterious effect on the bone marrow, but in spite of these disadvantages sulfonamide prophylaxis is the only concrete measure now available which will reduce mortality and morbidity due to rheumatic fever.

Davis⁵ reports 5 cases of apparently cured acute rheumatic heart disease by the use of sulfanilamide. All of his cases seemed to have become, after a certain time, free of pain; murmurs disappeared and the sedimentation rate came down very low. Of course, these patients need to be followed for a long time, as we know from past experiences that many cases of rheumatic heart disease are dormant for a long time only to become acute again and present symptoms much more serious than during the first attack.

There are many drugs used now in the treatment of myocardial failure, but above all it is of the utmost importance that absolute rest, moderate restriction of fluids and a salt free diet be used in treating these patients. The intake and output of fluids should be measured daily.

The three groups of medication used in the treatment of myocardial failure are (1) xanthine derivatives, (2) mercurial diuretics, and (3) digitalis. I believe that these drugs can be used in the order named, as the simplest and most easily administered are the xanthine derivatives. The optimal dose of these drugs is from 3 to 5 grams daily, divided into three doses. One may use either theocaine (theobromine calcium-salicylate) or thesodate (theobromine sodium-acetate) or diuretin, the last being less effective than the other xanthine derivatives.

Now as to mercurial diuretics, either salyrgan or mercupurin may be used if the congestive failure is not controlled by the xanthine compounds. Either may be given in the dosage of 1 cc. intravenously, and in smaller children 0.5 cc.

When salyrgan is used repeatedly the

urine must be examined for possible renal damage, as this drug is certainly contraindicated when renal damage is present.

Walsh and others recommend that the mercural diuretics be occasionally preceded by the use of 3 to 4 grams of ammonium chloride for twenty-four hours.

Digitalis has been used in the treatment of rheumatic heart disease and congestive failure in children for many decades. The real indication for its use is long standing, chronic congestive heart failure which recurs on slight provocation. Digitalis under these circumstances may be of great help and prolong life for some time. The next indication for the use of digitalis is auricular fibrillation. In these cases it is necessary to control the ventricular rate between 70 and 80.

When one administers digitalis to young children it is of the utmost importance that the initial dose be small in order to test the patient's sensitivity to the drug. The maximum effect may be obtained if the drug is given in the dose of $1\frac{1}{2}$ grains U.S.P. per 10 pounds of body weight.

Walsh⁶ has called attention to the fact that it is very dangerous to exceed the maximum dose of digitalis given to children, as serious cardiac disturbances may be seen while they are under digitalis therapy.

While auricular fibrillation is usually treated by digitalis, we many times see auricular fibrillation occur while taking digitalis. Sudden death in patients, showing toxic effects from digitalis other than auricular fibrillation, such as bigeminal rhythm due to ventricular premature beats, and in one case to heart block, has been reported. Most writers agree, however, that when the dosage of digitalis is properly controlled it is useful in the treatment of rheumatic heart disease and congestive failure in spite of its potential dangers. They usually give these patients $1\frac{1}{2}$ grains of digitalis three or four times daily until the total dosage is reached as estimated by Egleston's method. Sometimes when the patient is very ill they do not hesitate to give the full calculated amount in two or three doses over a period of eighteen to twenty-four hours. The effect of this drug

can then be continued by the use of 1 to $1\frac{1}{2}$ grains daily.

Since these writers have called our attention to the possibility of toxic effects of digitalis it is urged that electrocardiograms be taken at frequent intervals, at least every three days until the full dose of digitalis has been given, so that its effect can be observed, especially on auriculoventricular conduction.

Occasionally 10 to 20 cc. of 50 per cent solution of hypertonic glucose may be given intravenously for its direct effect. When pulmonary edema develops venesection may be a lifesaving measure. About 2 cc. per pound of weight may be withdrawn. Should cyanosis develop, oxygen should be used with the patient in a tent. Many times one sees the use of a funnel or a nasal catheter which, of course, is of little value as far as the administration of oxygen is concerned. Oxygen should be used early as there seems to be very little value from its use late in this disease. All other measures for comfort, such as codeine and morphine when the outlook appears hopeless, should be given in order to make these patients as comfortable as possible.

Following the acute phase the patient goes into the quiescent phase, to be followed by a period of convalescence. Taran has defined the state of quiescence as the time when a patient presents a history of rheumatic fever and at the time of examination does not present physical or laboratory evidence of active infection. Should there be an interruption of the quiescent phase by obvious signs of rheumatic infection, we must say that we have a recurrence of this disease.

One of the most difficult problems during convalescence is the diagnosis of the presence of myocarditis. The simple signs, such as pain in the joints or nodules may disappear, but there still remains the possibility of mild infection which cannot be diagnosed very easily; and secondarily, involvement of the heart. The pulse rate, temperature and respiration must remain normal even in the absence of evidence of cardiac damage, as acceleration of these definitely indicates that an active infection is still present.

During this period an electrocardiogram is of great benefit to the physician. The most common abnormality found in an electrocardiogram reading is the conduction time — 0.18 second should be the upper limit in conduction time in a child ten years of age or under. However, the electrocardiogram does not always present definite proof that no abnormalities in the heart exist. It is of utmost importance that we correlate the findings in the electrocardiogram with the clinical signs and symptoms present.

During this period the temperature of the patient is one of the most important guides as to his recovery. If the temperature remains normal for several days it should lead one to believe that the patient is improving. A rise in temperature during exercise should be carefully considered, as many convalescent patients will, on the least exercise, develop a rise in temperature. Tachycardia is also of importance when it is due to rheumatic infections, but there are many extraneous factors — psychic in origin — which may be responsible for tachycardia. These should be carefully investigated by the attending physician so as to be assured that the tachycardia is due to no other factor except the existent infection.

White blood counts should be made regularly and compared with previous counts, and the sedimentation rate should be watched so as to be assured that it is going down and the patient is showing improvement. But even when all signs of active infection have apparently disappeared, there are still many difficulties presented to the physician in definitely establishing the quiescence of rheumatic infection. The difficulty in diagnosis of continued infection leads one to be on guard in making a prognosis.

Taran⁷ feels that the usual clinical criteria, such as temperature, pulse rate, blood tests and cardiographic abnormalities do not determine the entire story. He believes that the single criterion for continued treatment is the finding of active manifestations of the disease, and that sometimes this is most difficult to accomplish. For that reason it is difficult to give a prognosis unless

each individual patient is studied thoroughly.

Proper medical management should aim, according to Taran, toward the following: (1) The arrest of active rheumatic progress, (2) prevention of recurrent attacks, (3) prevention of cardiac damage, (4) prevention of psychic disturbances attendant upon chronic protracted illness, and (5) salvage of many of those who are considered hopeless cardiac patients.

The first three can be aided by long convalescence, which certainly influences the course of this disease; and it has been shown by many writers that the incidence of rheumatic recurrences is definitely lower if patients are given a long convalescent period. Certainly the incidence of rheumatic recurrences is proportioned directly to the number of new involvements of the heart, which lead to further cardiac damage and finally fatal results. Thus it has been shown definitely by Taran and others that the incidence of rheumatic recurrences is certainly lower during and following convalescent care than preceding it. It is also of the utmost importance that these patients be kept not only in general good health, but there must be a constant gain in weight, as loss of weight in a rheumatic patient certainly would indicate rheumatic activity, and the latter will lead to cardiac activity. Convalescence will help to produce a gain of weight, and in this way to prevent cardiac damage.

The relation of upper respiratory infections to rheumatic heart disease brings conflicting opinions to anyone who has read the literature on this subject. Coburn and Pauli⁸ believe that there is some relationship between respiratory infection and the onset or recurrent attacks of rheumatic fever. Jones and Mote⁹ believe that two-thirds of rheumatic recurrences are associated with infections of the upper respiratory tract, while Wilson, Ingerman, DuBois and Spock¹⁰ do not believe that upper respiratory infections bear a specific relationship to this disease.

The question naturally arises whether the patients with attacks of rheumatic disease of any form should have their tonsils removed. There are also many conflicting

opinions on this question. I do not see from our experience in the wards of Grady Hospital that tonsils *per se* bear direct relationship to rheumatic infection as has been taught for many years. Certainly this theory does not coincide with the fact that chorea occurs in tonsillectomized patients. If the tonsils *per se* are infected they should be removed, otherwise one should be discriminating in the removal of tonsils in rheumatic infections.

Whether climate plays a great part in reducing recurrent rheumatic infections cannot be definitely proven. We do know, however, that tropical climates are a great aid in cutting down recurrent attacks of rheumatic fever as well as cardiac damage, and children should be sent to such climates if possible.

From a sociologic angle, rheumatic heart disease presents many problems, as it is usually a disease of the poor. Proper home environment and proper food can help along these patients. Social service departments of hospitals should follow these cases up and prepare proper home environment and good food and fresh air for poor children who are rheumatics. These departments can advise them as to their living conditions, including exercise, rest and in the learning of proper trades. Many of these children do well in sanatoriums and should be sent there for their convalescence. As far as the hopeless cardiacs are concerned, they must come into the hospital again and again and must be made as comfortable as possible, as there is very little hope for many but a fatal termination in their cases.

From a sociologic, as well as prophylactic angle, the study made by Wilson¹² on the occurrence of rheumatic fever in certain families is most interesting. In this study she points out that while environment and climate play a great part in the etiology of rheumatic disease, the susceptibility to this disease can be evaluated by the study of the occurrence in the whole family. From her study she makes the following deductions and I will quote her verbatim: "If both parents are rheumatic, nearly every child will be susceptible; if one parent is rheumatic and the other is non-rheumatic,

but a carrier, each child has a 50 per cent chance to be susceptible. If neither parent is rheumatic, but both parents are carriers, each child has a 25 per cent chance to be susceptible; if one or both parents are negative or noncarriers, susceptible children would be unlikely, or the probable chance would be about 3 per cent."

Knowing also the possibility of susceptibility to this disease in different parts of the United States we would be able, by studying different families, to get the exact information of the role of climate and environmental disease. Especially is this study of importance because it is through the study of the potential rheumatic families that Dr. Wilson believes further research of rheumatic fever can be followed up.

Conclusions

Rheumatic heart disease is becoming a greater problem than ever. We have now between one-half and one million rheumatics in this country.

As yet we do not know the exact etiologic factors, nor do we have drugs which will terminate this condition after a single attack.

This condition is most serious, because the average child that is attacked is young, and the younger the child the quicker the fatal termination.

Since we have nothing definite to work with it should be our purpose to attempt in every way to arrest active rheumatic heart disease and to follow some of the suggestions outlined in this paper, so as to prevent further cardiac damage and improve the psychic condition of these patients in order to salvage as many cases as possible.

BIBLIOGRAPHY

1. Taussig, Helen B.: The Management of Children with Rheumatic Heart Disease. *M. Clin. North America* 18: 1559 (May) 1935.
2. Hansen, Arild E.; Platou, Ralph V., and Dwan, Paul F.: Prolonged Use of a Sulfonamide Compound in Prevention of Rheumatic Recrudescences in Children: An evaluation based on a four year study on sixty-four children. *Am. J. Dis. Child.* 64: 963 (Dec.) 1942.
3. Pennoyer, Miriam M., and Hansen, Arild E.: Preventing Rheumatic Recrudescence: Consideration of Several Modes of Prophylaxis Available to Rheumatic Patients, *Lancet* 64: 139-141 (May) 1944.
4. Slocumb, Charles H., and Polley, Howard F.: Prophylactic Use of Sulfonamide Compounds in Treatment of Rheumatic Fever. *M. Clin. North America* 28: 838-843 (July) 1944.
5. Kuttner, Ann G.: Sulfonamide Prophylaxis for the Prevention of Rheumatic Recurrences, *J. Pediat.* 26: 216-219 (March) 1945.
6. Coburn, A. F., and Moore, L.: *J. Clin. Investigation* 18: 147, 1939.

7. Davis, Henry C.: Acute Rheumatic Heart Disease Apparently Cured by Sulfanilamide, West Virginia M. J. 28: 58 (Feb.) 1942.
8. Walsh, Bernard J., and Sprague, Howard B.: The Treatment of Congestive Failure in Children with Active Rheumatic Fever, J. A. M. A. 116: 560 (Feb.) 1941.
9. Taran, Leo M.: The Value of Convalescent Care for Rheumatic Children, J. Pediat. 18: 737-749 (June) 1941.
10. Coburn, A. F., and Pauli, R. H.: J. Exper. Med. 62: 129, 1935.
11. Jones, T. D., and Mote, J. R.: J. A. M. A. 113: 898, 1939.
12. Wilson, M. G.; Ingerman, E.; DuBois, R. O., and Spock, B. M.: J. Clin. Investigation 14: 325, 1935.
13. Modell, W.: The Optimal Dose of Mercural Diuretics, Ann. Int. Med. 20: 265-274, 1944.
14. Wilson, May G.: Hereditary Susceptibility in Rheumatic Fever, The Potential Rheumatic Family, J. A. M. A. 124: 1188 (April) 1944.

CORONARY HEART DISEASE: DIAGNOSIS AND TREATMENT

JOHN W. BRITTINGHAM, M.D.
Augusta

It is hardly necessary for me to call your attention to the gravity and prevalence of this type of disease. Coronary disease has been labelled all too correctly as "The Doctors' Disease." Most of us see some forms of it in our practice almost every day in the week. Time does not permit a lengthy comprehensive discussion like the classic delivered by Dr. Chauncey C. Maher, of Chicago, before our Ninety-fourth Annual Session in Atlanta last year, but I am in hopes that my remarks will serve the purpose of enabling us all to understand this dramatic and often tragic manifestation of arterial disease.

I shall limit my essay to a few observations made in regards to its diagnosis and treatment, but first let us examine a few slides that will make the entire clinical picture very much more simple.

Here is illustrated the normal coronary arterial distribution in a person in the fourth decade of life. Note that the vessels are straight, and not tortuous as in the next preparation. Next are the coronary vessels of a man in his 74th year. By comparison observe the straight vessels in the coronary blood supply of an infant. The transitions from this stage to the more twisted and tortuous vessels that begin to appear at the usual onset of coronary disease may be compared to the same change from the limbs of a straight young sapling to those of a gnarled old oak. The more pronounced the tortuosity and loss of elas-

ticity become in the coronary bed the more prevalent and evident will be the appearance of coronary disease.

In diagnosis we must distinguish between acute and chronic coronary disease, the diagnostic signs of which are known to us all. However, I would like to emphasize the increasing recognition of the so-called atypical forms. Textbooks are crowded with the usual syndrome of substernal pain, referred to left arm, jaw, etc., and the concomitant drop in blood pressure. I have observed many proven cases of coronary occlusion without any cardiac pain whatsoever, but with pain or numbness alone in the left elbow and arm. In fact, as far as this part of the country is concerned we should not be too hasty in attributing all substernal pains to coronary disease, on account of the high incidence of aortitis, which is one of the chief causes of such discomfort. This association always brings to my mind the chapter in that clever book of Hyman and Parsonnet on *The Failing Heart of Middle Life*, where reference is made to the controversy between "coronarians" and "aorticians." Indeed there are many coronary occlusions that occur without *any* pain, depending on whether the vessel is closed gradually by arteriosclerosis or suddenly and dramatically by thrombosis. The pain in the textbook case is the most severe pain known to mankind, and sculptors and painters have attempted to reproduce it on the faces of their subjects. Such patients with occlusion are actually in a state of shock which is almost identical with surgical shock as far as blood pressure, pulse rate, temperature, etc., are concerned. However, reference to this will be made later when treatment is discussed.

You will note that I am restricting acute coronary disease to what we know to be coronary occlusion. It is perfectly obvious that we can recognize this condition in many if not most of our patients, but actually the proof of its existence very often depends upon the electrocardiographic findings. These are not at all difficult to understand, and for the most part are manifested by certain characteristic changes in the so called T waves.

The true and more interesting diagnostic problems are encountered when we study chronic coronary disease. This usually has an insidious onset and makes its first appearance with vague symptoms of slight dyspnea and tachycardia on every-day exertions, and gradually becoming more evident and accompanied by slight substernal oppression. These are signs of coronary insufficiency and are precursors of angina and occlusion. They are warning signs to "take it easy" or "slow down." At this stage there are no characteristic electrocardiographic changes from the normal, not even in the presence of severe angina pectoris in most patients. However, on fluoroscopy the finding of an aorta which is more tortuous and inelastic than that for a person of a certain age period makes it logical for one to infer that that particular individual has similar coronary vessels, and is therefore a candidate for an occlusion. It is believed that all patients with angina are such candidates, and clinical experience substantiates this belief.

I will not waste time describing angina and its symptoms — it is too well known by most doctors — but I would like to call your attention to some particularly beneficial and useful therapeutic measures in both acute and chronic coronary disease. Much has been written about the immediate administration of morphine in substantial doses to the victim of an occlusion, but very little has been said about the method of administration. I will venture to say that in nine out of ten cases the average colleague of ours, on the strong suspicion of this cardiac tragedy, would give morphine hypodermically in the conventional sites such as the arm muscles, etc. In a true occlusion relief is not experienced and in due course of time another injection of morphine is frequently given. We must never overlook the fact that such patients really are in a state of shock. They are cold and clammy, with pulse pressures usually quite low — often as low as ten millimeters. While they are in this state of shock there is very likely to occur multiple constrictions of coronary vessels adjacent to the infarcted area. These often precipitate additional and fatal occlusions. Therefore

when morphine is given to such a patient it should be administered *intravenously* in at least 0.030 Gm. ($\frac{1}{2}$ grain) doses. Relief from pain is much more rapid and often such a measure is a lifesaving one. It is easy to understand why the usual intramuscular morphine should remain near the site of injection when the patient's blood pressure is usually at a very low ebb. It is best not to be in too much of a hurry to rush these patients to the hospital, but whenever possible oxygen should be used. After the immediate crisis has passed all occlusion patients should receive the benefit of quinidine, which often has a prophylactic effect against ventricular fibrillation. The xanthine derivatives have established value, and it is an indisputable fact that alcohol in moderate doses also aids coronary dilation.

There is not any arbitrary length of time for rest in bed, but in general the younger the patient the longer the rest interval, because of the relatively smaller number of collaterals in the coronary system. The writer has obtained somewhat better results than with morphine by the intravenous injection of spasmalgin (Roche) which can be obtained in an ampul already in solution. Its contents are: papaverine hydrochloride $\frac{1}{3}$ grain and pantopon $\frac{1}{6}$ grain.

In regard to treatment of the chronic forms of coronary disease, at last an addition to the time-honored principles of rest, lessening responsibilities, etc., has been found. In 1938 while treating two men with testosterone for symptoms of the male climacteric it was observed by the patients themselves, who also suffered from mild angina pectoris, that they could walk longer distances without their usual fatigue and substernal oppression. Since that time I have treated 21 similar patients, all of whom showed definite improvement in regards to exercise tolerance. Many reports of similar favorable responses to this type of treatment have appeared in the literature since then. The most approved plan is to administer 25 milligrams of testosterone intramuscularly at five to seven-day intervals for a course of twenty-five injections. I have tried the oral forms of this synthetic hormone in a few patients but have not ob-

tained as good results — not even with the sublingual tablets. One patient, aged 77, is enjoying the benefits of a single subcutaneous implantation of testosterone pellets, which were implanted by Dr. Robert Greenblatt. Stilbestrol and kindred female hormone preparations have effected similar responses in the female. Incidentally, coronary disease is being found with increasing frequency in the fair sex.

Aminophylline, theophylline and similar drugs certainly have great value, and small doses of the barbiturates have helped many victims endure the pangs of anxiety and fear that we find in so many of these patients.

In conclusion, let me reiterate that it has not been my intention to present an exhaustive study of this type of disease. The chief points I have emphasized are:

1. Coronary disease is not the clean-cut syndrome described in textbooks.
2. Coronary occlusion often occurs without any pain.
3. In the acute occlusion opiates are of much more value if administered by the intravenous route.
4. Chronic coronary disease is not always the hopeless condition considered for years.
5. Coronary insufficiency and angina are often improved very much by hormone therapy.

OLEOMARGARINE AND THE COUNCIL ON FOODS AND NUTRITION

Misinterpretation is being placed on the action of the Council on Foods and Nutrition in withdrawing acceptance from individual brands of oleomargarine. Reports published in the periodicals devoted to the interests of the dairy industry and comment stimulated in the public press falsely attribute this action to a lack of confidence in the nutritional value of margarine. Such is not the case. The report of the Council on Foods and Nutrition in *The Journal*, Sept. 16, 1944, stated clearly that margarine is considered a general purpose food and therefore outside the Council's scope of acceptance, now limited to "special purpose" foods. For this reason acceptance is no longer granted to margarine. Confidence in the nutritional value of margarine fortified with vitamin A was reaffirmed by the Council at the time acceptance was withdrawn. The attempts of those opposing margarine to cast doubt and suspicion on its food value as a result of the withdrawal of acceptance by the Council are unwarranted and misleading.

PAIN IN THE CHEST: ITS SIGNIFICANCE

C. C. AVEN, M.D.

Atlanta

Since pain is probably the most frequent symptom that attracts the attention of the patient, it is the one thing for which he or she seeks relief. My interest in the subject of pain in the chest is largely due to my inability to find the etiologic factor; therefore, an evaluation of methods used is in order. Have we sought new procedures? Or do we fail to fully utilize those at our command?

With the use of x-ray, bronchoscopy, visualization of bronchi by bronchiograms and other laboratory tests, our knowledge of the lungs and pleura is fairly complete, but still we are at a loss in many instances to ascertain the cause of pain in the chest.

Acute pain tests the diagnostic acumen of the physician, but chronic pain is of utmost concern to the patient and the phobia of tuberculosis and cancer add to their apprehension. How often do these two diseases produce pain? Statistics are somewhat at variance. To add to our confusion it may be an insignificant phenomenon of some very distressing chest disease, or it may be of very severe character due to some disease outside the thorax, as cholelithiasis, subdiaphragmatic abscess, etc. The lack of the patient's ability to describe the pain after cessation is of importance but confusing.

Pain may vary from a slight ache to a very severe agonizing suffocation type of pain, as in spontaneous pneumothorax. To further add to the state of confusion may be the sensitivity of the patient to pain or the nervous or mental state. Again we should not be confused by the presence of two clinical entities, one of which may be aggravated by the other, as angina from the various acute abdominal diseases. Let me here dismiss the cardiovascular disorders from the discussion except to say that the relation to pain from exertion, relief by

rest, or administration of nitrites and electrocardiographic evidence should suffice to give presumptive diagnosis.

CAUSES OF PAIN IN THE CHEST

A. Causes from pulmonary and pleural disease:

1. Pleurisy — acute and chronic
2. Pneumonia
3. Newgrowth
4. Spontaneous pneumothorax
5. Massive or lobular atelectasis
6. Pulmonary or mediastinal abscess
7. Pulmonary infarction
8. Bronchitis
9. Bronchiectasis
10. Tuberculosis
11. Spontaneous and mediastinal emphysema (Hamman)

B. Causes from esophageal lesions:

1. Cardiospasm
2. Esophagitis
3. Carcinoma

C. Causes from abdominal disturbances:

1. Peptic ulcer
2. Gallbladder disease
3. Subphrenic abscess
4. Liver abscess

D. Causes from thoracic wall and spine:

1. Metastases
2. Spondylitis
3. Bursitis
4. Myalgia
5. Osteitis or osteomyelitis of the ribs
6. Mastitis
7. Trauma

E. Causes from disturbances of the nervous system:

1. Intercostal neuralgia
2. Neuroma
3. Herpes zoster
4. Pressure on nerve roots
5. Spinal cord tumor
6. Tabes dorsalis

Too much emphasis on location, character, and radiation of pain rather than the circumstances under which it occurs often lead to error in diagnosis.

Such exceptions are pylorospasm, duodenal ulcer or gallbladder disease, any or all of which may produce pain in the chest. This pain may be referred to substernal or left shoulder regions, simulating cardiac disease. A certain type of pericarditis occurs in winter and during epidemics of acute respiratory infection which is characterized by sudden onset, stabbing pain, intensified breathing, but less constriction than the pain of coronary disease. The pain of mediastinal lymphadenitis, peptic ulcer,

gallbladder disturbance or any other disease that causes upper abdominal pain referred to chest, neck, shoulders, or arms, is disconcerting unless the relationship to effort-syndrome is present. If so, angina pectoris should be the preferential diagnosis. These conclusions are drawn by Tinsley R. Harrison in article discussing some puzzling aspects of pain in the chest.

T. G. Heaton reported in 1942 on 341 consecutive cases referred to an Army consulting clinic, 100 of whom complained of chest pain. Diagnoses were: psychoneurosis 58 per cent, lower respiratory disease 22 per cent, and intercostal neuralgia 16 per cent. Others were spinal disease, heart disturbance, injury, dyspepsia, etc. In private practice would such a large percentage be charged up to psychoneurosis?

The pain was characteristic in all groups except those with injury or spinal disease, in whom the pain was felt more commonly posteriorly or posterolaterally, while in others it was anterior or anterolateral and below the third rib; never substernal and more often on the left side, but occasionally bilateral. X-ray and electrocardiographic evidence were negative.

Excluding pain due to cardiac disease and vascular changes, we will discuss the most dramatic but not most frequent cause of pain in the chest. It is due to spontaneous pneumothorax, usually of sudden onset, and usually in a young adult. The pain is most often sudden and the patient describes the time and place of its occurrence. The onset may be insidious and cause little pain, shortness of breath, cold perspiration, pallor, and extreme mental distress. Cyanosis may be present. Physical signs are: absent or distant breath sounds, and lagging on the side affected. Confirmation may be had by fluoroscopic or x-ray examination, or both.

Less dramatic may be the pain of acute pleurisy or of pneumonia. Pleuritic pain is lancinating, aggravated by normal breathing. Frequently a hacking cough is present. Diaphragmatic pleurisy is often referred to the trapezius muscle, to the shoulder or around the margin of the chest to the abdomen. It is often overlooked because of the absence of the friction rub.

The tuberculous patient sooner or later experiences pain resembling the pleuritic pain here described, though not always as acute. Friction rub, if present, is diagnostic of pleurisy irrespective of the etiologic factors.

Pain in bronchitis is usually substernal and occurs with coughing.

Bronchiectasis may give a picture of acute pneumonitis with pain, bloody sputum, etc. This is due to spread by acute infection and often is called suppurative pneumonitis.

Richard Overholt calls cancer of lung "the masquerading disease" and aptly so. The sudden appearance of pain, dyspnea or hemoptysis without evident cause in a man past midlife, indicates cancer and I say man reservedly because of the much greater frequency of cancer in the male. Pain may be an early symptom or it may occur later. Pleuritic pain from cancer is not relieved by pleural exudate which, if bloody, is almost pathognomonic. The sedimentation rate and unexplained progressive anemia are helpful in making the diagnosis, especially if the presence of cancer is suspected. Verification may be had by x-ray examination, and bronchoscopy with biopsy.

Spasm of the esophagus or cardiospasm may lead to substernal pain, regurgitation of food or vomiting. The intermittent character, relation to meals and relief from nitrites may confuse the unsuspecting, and a diagnosis of angina or coronary disease may be made. Fluoroscopic and x-ray examinations are usually helpful.

Involvement of the nerve roots of the spinal cord may cause pain without other manifestations.

Arthritic changes, tumors of the cord, caries of the vertebrae, tabes dorsalis, and neuritis due to toxins of various kinds may only be diagnosed when their existence is given consideration. The pain is often sharp or the lancinating girdle type.

Massive atelectasis two decades ago was probably called "ether pneumonia." The history of an anesthetic and operation, the early onset after the operation, with pain, rapid respiration, cough, blood-tinged sputum and physical signs of rales, impaired

resonance and displacement of mediastinum and contents to affected side, offer the explanation. X-ray examination is confirmatory. Bronchoscopic suction is lifesaving therapy.

Pulmonary infarction, if the pleura is involved, may cause severe pain. A high percentage of cases occur about twelve to fifteen days postoperatively, or in the presence of valvular heart disease, or in phlebitis. Signs and symptoms are: abrupt rise of fever and pulse rate, friction rub if large, with impaired resonance and tubular breathing. Sudden death may occur. X-ray examination is very helpful.

Pleurodynia, or intercostal fibrositis, is manifested by unilateral pain of diffuse distribution, which is intensified by deep breathing, coughing, or yawning. It is more common on the left side but may migrate from side-to-side. There is diffuse tenderness.

Intercostal neuralgia and herpes zoster may create confusion but the appearance of herpes clarifies the diagnosis.

Pain in the chest may be due to allergic reactions, especially to nicotine.

The frequency of pain in the breast of women is an impressive symptom and is probably unexplained in many instances. Phobia of cancer cannot explain these cases.

Interstitial mediastinal emphysema is painful; it is rare but dramatic, and simulates coronary disease. Hamman has described this and the classical unusual bubbling or crunching sound that occurs with each cardiac apical impulse, usually heard better in the prone position. X-ray studies reveal this diagnosis by showing the presence of air in the mediastinum.

F. M. Pottinger has discussed the recurrent pain over the lower portion of the chest in patients who have previously had pleurisy. Chronic inflammation produces degenerative changes in muscles, in skin and in subcutaneous tissues. The pain may be severe or just an ache, or it may extend down in the abdomen and cause confusion with acute abdominal conditions. There is often a furrow following the affected nerves. This pain is affected by weather, menstruation, or the presence of nervous or emotional distress.

Certain of chest pains described with areas of hyperesthesia and a "light feeling" in the region complained about can be reproduced by inflating the stomach or colon with air.

Various functions of the body have a definite relationship to pain, therefore every patient with pain in the chest should not be subjected to all the various laboratory, x-ray and other expensive examinations without a careful painstaking history.

A good analysis of an elaborate history gives a clue to the correct diagnosis, and then some particular study may be indicated. No place in medicine should place emphasis on the clinical side more than when one is confronted with chest pain. If this is kept in mind, then many pitfalls can be avoided.

Conclusions

1. There are about seventy-five listed causes of pain in the chest, therefore it is a symptom with many possible explanations.

2. That emphasis must be placed on a detailed history, and proper evaluation of all possibilities.

3. X-ray examination frequently fails to offer explanation of the pain.

4. That there may be various causes for pain in the same site.

5. That the order of frequency is as follows:

- a. Strain or trauma of the chest wall.
- b. Indigestion with cardiospasm.
- c. Lung and pleural involvement.
- d. Gallbladder disease.
- e. Coronary disease.

REFERENCES

1. Yater: Symptom Diagnosis, ed. 4.
2. Cecil: Textbook of Medicine, ed. 6.
3. Osler's: Principles of Practice of Medicine, Christian, ed. 14.
4. Meakins: Practice of Medicine, ed. 3.
5. Heaton, T. G.: Canad. M. A. J. (Dec.) 1942.
6. White, Paul D., and Spillane, J. D.: The Differential Diagnosis of Chest Pain, M. Clin. North America, 1939.
7. Harrison, Tinsley R.: Some Puzzling Aspects of Pain in the Chest, J. A. M. A. (Oct.) 1942.

NEW STUDY SHELVES OLD THEORY THAT DYES CAUSE SKIN TROUBLE

Many people, especially women, believe that painful and itching skin irritations which they sometimes suffer are caused by dyes in wearing apparel. But two physicians, writing in the August 25 issue of *The Journal of the American Medical Association*, state that dermatitis or skin inflammation due to fabric dyes is relatively infrequent today.

"It has been shown that in most instances the dermatitis was caused by the finishes rather than by the dyes," the doctors report. Finishes are placed in fabrics to give them a better appearance such as luster, better feel and wearing properties, to prevent runs and unraveling, and to make fabrics noncreasing, waterproof, mothproof, flameproof and moldproof.

The doctors who report their study in *The Journal* are Louis Schwartz, Medical Director, and Samuel M. Peck, Senior Surgeon (Retired), both of the U. S. Public Health Service, Bethesda, Md.

The two authors point out that "when dermatitis is caused by the dyes, it is usually due to an idiosyncrasy to the dye itself or to a faulty process of dyeing, so that there is retained in the fabric some chemical which should not have been present. On occasion, dyes will cause dermatitis if one of the known sensitizing dyes is used. When dyes themselves have been found to be the cause of the dermatitis it has been usually found that they easily come out of the fabric or 'bleed.' Conditions on the skin surface may help to determine the 'bleeding' of the dyes from the fabric. For instance, some will bleed out in acid perspiration and others in alkaline. Since some of the dyes are soluble in fat solvents, a high fat content on the skin surface may help dissolve them out."

A patch test, they say, is now being used by manufacturers to determine the possible skin irritating or sensitizing properties of wearing apparel containing new chemicals before placing them on sale to the public.

For diagnostic purposes, a piece of the material or the substance to be tested, in a patch of about one inch square, is allowed to remain on the skin for 48 hours.

It requires considerable experience to interpret reactions to patch tests correctly. The test is usually made on 200 or more individuals. Two series of patch tests are carried out on the same individuals 10 to 14 days apart. The first series of tests would give reactions only with a primary irritant or with people who have been sensitized by previous contact with the chemical. The second series shows the number sensitized by the first series. "Experience has shown," the investigators state, "that even one positive reaction among the second series may indicate that the test substance is a sensitizer which might lead to outbreaks of dermatitis if allowed to be used by large groups of people."

PUBLIC HEALTH CONDITIONS IN GERMANY GOOD

General of the Army Dwight D. Eisenhower, in a report to the United States Joint Chiefs of Staff dated 20 August 1945, said that in general, the health conditions of the civilian population in Germany are good.

Due to damaged water and sewer systems, some local epidemics of dysentery and typhoid fever have occurred, although typhus incidence has declined. Loss in body weight has resulted from the low general level of food consumption. The average daily diet for normal adults is estimated at between 1,150 and 1,730 calories. Displaced persons have been receiving a minimum of 2,000 calories.

FUSED KIDNEY, HAVING SUPERNUMERARY
URETER WITH EXTRAVESICAL ORIFICE;
TREATED BY HEMINEPHRECTOMY
OF THE LEFT HALF

J. ROBERT RINKER, M.D.
Augusta

REPORT OF CASE

H.B., a female aged 13, who had complained of leakage of urine since birth for which she had always worn a pad, was seen by Dr. J. R. Howell of Aiken, S. C., and referred to me.

Examination of the patient disclosed a small opening in the midline just below the normal urethral meatus through which urine was seen to spurt about every four minutes. This urine contained a few pus cells. She also voided at normal intervals. There was no history of fever or renal tenderness.

A urethral catheter was passed through this opening and an x-ray and retrograde pyelogram demonstrated readily that this was an extravesimal opening of the left ureter. Cystoscopic examination revealed a normal bladder with a normal ureteral opening on each side through which clear urine was spurting. The ureters were catheterized and P.S.P. appeared in four minutes from both the right kidney and lower pelvis on the left side with good concentration. Retrograde pyelogram disclosed a normal ureter and renal pelvis on the right and a double ureter and double renal pelvis on the left. The ureter draining the upper left pelvis by-passed the bladder to open in the vaginal vestibule. This bears out the statement of Scott¹ that "in cases of duplication of the pelvis and ureter, the cephalic pelvis is always drained by the ureter which inserts caudally and medially."

An intravenous urogram was also made with the same findings as the retrograde studies. The right kidney pelvis and lower pelvis on the left filled well and showed good excretion of the diodrast in five minutes. The upper pelvis on the left showed poor excretion and poor filling. The calices (see illustration) do not face medially as frequently seen in a fused (horse-shoe) kidney, but a shadow suggesting the presence of an isthmus can be seen on the x-ray, and the kidney pelves also lie close to the spine which is characteristic.

On admission to the University Hospital her bladder urine had a Sp. Gr. of 1.010 and was negative; W.B.C. 6,750; R.B.C., 4,710,000; hemoglobin 14.5 grams. General physical examination, negative. Blood pressure: 110/70.

Operation: A left loin incision was made and left half of the fused kidney was mobilized and isthmus severed in the midline. Examination of the left half of this kidney showed the upper half to be contracted, characteristic of chronic pyelonephritis; the lower half was normal, and had a separate blood supply. A heminephrectomy was done removing the contracted upper half which contained the upper renal pelvis. The site of amputation in the remaining lower half of the kidney was closed, using fat for hemostases. A nephropexy, using Gerota's fascia, was done so that the remaining lower half of the left kidney would be in the most

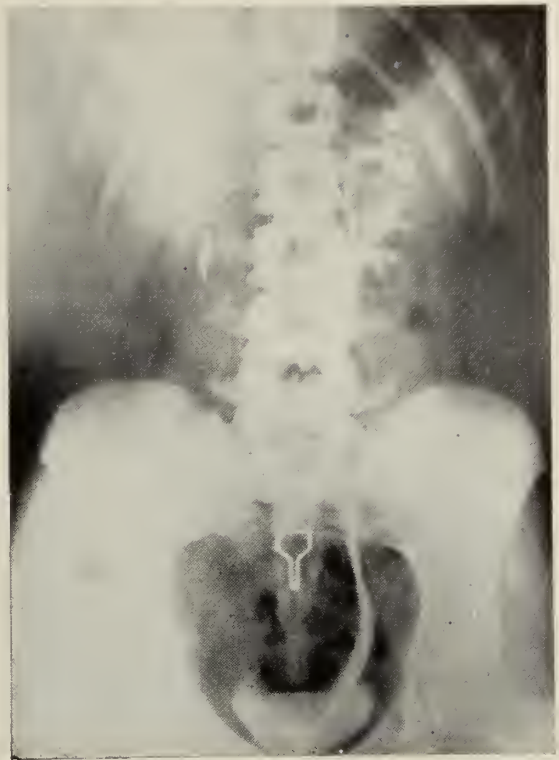


Figure 1.

The isthmus is seen crossing in front of the spine and the renal pelves lie close to the midline, which is characteristic of a fused kidney. The upper half of the left side shows clubbing of the minor calices which is characteristic of chronic pyelonephritis. The supernumerary ureter from the upper renal pelvis on the left can be seen by-passing the bladder.

favorable position for good drainage. The incision was closed with drainage. Convalescence was uneventful and she returned to her home on the eleventh post-operative day. The result has been quite satisfactory.

Pathologic Report: Dr. Edgar Pund: "Chronic ureteritis and pyelonephritis; lymphocytic infiltration with some scarring of the parenchyma."

Discussion

Leakage of urine anywhere in the vagina or region of the urethra occurring in spurts at regular intervals should suggest the possibility of an extravesimal ureteral orifice. Fused (horse-shoe) kidneys usually lie lower and do not drain as well as normal kidneys. In operating on a fused kidney for any cause, unless there is a good contraindication, it is well to sever the isthmus and do a nephropexy on the mobilized half, fixing it in a position most favorable for good drainage. The fact that the renal parenchyma drained by the upper pelvis and extravesimal ureter was contracted due to chronic pyelonephritis, while the lower half drained by the pelvis and ureter which inserted into the bladder was normal, is an excellent example of the protective role the bladder and urethra play in preventing upper urinary tract infection.

BIBLIOGRAPHY

1. Scott, W. W.: Supernumerary ureter with extravesimal orifice; report of four cases. *J. Urol.* 52: 126-132 (Aug.) 1944.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

NOVEMBER, 1945

ANNUAL SESSION OF THE ASSOCIATION

Plans are under way for the next annual session of the Medical Association of Georgia, to be held in the City Auditorium, Macon, May 7-10, 1946.

It is not too early to begin preparation of the paper you plan to present before the Association, granting the Committee on Scientific Work accepts it for a place on the program. Communications to this committee should be sent now to the chairman, Dr. B. H. Minchew, Waycross.

Members of the Association, and others, whose plans include a scientific exhibit, should communicate with the chairman of the Committee on Scientific Exhibit, Dr. W. F. Hamilton, University of Georgia School of Medicine, Augusta, giving an estimate of the amount of space needed for such exhibit.

Members are reminded that the business sessions of the Association are conducted by the House of Delegates, and that all proposals dealing with such business should first be approved by the county medical society of which you are a member, the proposal or proposals being made to the House by your delegate or delegates. Such procedure is not necessary in the work of the officers and committees of the Association.

The Bibb County Medical Society, of Macon, is a gracious host and all persons attending this annual session should profit in many ways, so make your plans now for attendance at what should be one of the most successful sessions of the Association—an association which was founded in the City of Macon ninety-six years ago, and an association which has grown in numbers, knowledge and prestige with the passing of the years.

ECONOMIC ISSUES FACING HOSPITALS THEME OF SECOND HOSPITAL REVIEW

The future of American hospitals and some of the economic issues confronting the voluntary system receive careful consideration in the second book of the 1945 *Hospital Review* which substitutes for the annual convention of the American Hospital Association, George Bugbee, executive director, announced. This volume, discussing expansion of facilities, Blue Cross, the Commission on Hospital Care, hospitalization of veterans, the care of the medically indigent, and other hospital problems, will be distributed to association institutional members the first part of November.

Prefaced with an interpretation of the grow-

ing responsibilities of the voluntary hospital in the light of economic trends and public desires, the book treats in some detail fields in which hospitals may effect great advances for improved hospital service to their communities.

In a statement on Federal grants-in-aid for hospital surveys and construction, originally presented before a Congressional subcommittee considering the "Hospital Survey and Construction Act," the need for nation-wide planning of hospital facilities and for financial assistance to regions with limited funds for health facilities is explained. Federal grants, to be administered by state governmental authorities under the general supervision of the Surgeon General of the U. S. Public Health Service, would be used to inventory existing hospitals and health centers and determine the need for additional construction; to develop programs for the construction of hospitals and health centers which would afford adequate health facilities for all of the people; and to construct facilities in accordance with needs indicated by such surveys.

Some of the administrative difficulties encountered in the first studies and an indication of the final reports of the Commission on Hospital Care, nation-wide analysis of hospital needs as compared to hospital facilities, are presented by Dr. A. C. Bachmeyer, director of study. Although the commission has not yet formulated or suggested specific policies, it has come across a number of broad problems confronting American hospitals today. These Dr. Bachmeyer outlines in "Some Problems Confronting American Hospitals," the first preliminary paper to be issued on the important two-year study being conducted nationally under sponsorship of the American Hospital Association and a commission whose members represent every segment of American life.

Expansion of Blue Cross plans to secure increased benefits and coordination with physicians' plans are treated in "Blue Cross Plans and Hospital Management," by John R. Mannix, chairman of the Hospital Service Plan Commission and head of the Plan for Hospital Care in Chicago. Positive action programs of public health by the plans, the enrollment of low-income groups, and unified programs in communities and states to include all hospitals are given consideration for the future.

"Hospital Care of the Medically Indigent," by Everett W. Jones, vice-president of the Modern Hospital Publishing Company, compares the various states' provisions for hospital reimbursement for care of the indigent. Preliminary measures by hospitals to facilitate the securing of adequate government payments are suggested—the accurate determination of total income and patient days of care for the indigent, cooperation among non-government hospitals in developing better administration for state, city and county hospitals, etc.

Treatment of short-term non-service-connected illnesses of war veterans in community hospitals is weighed in "Hospital Care for Veterans." Background experiences in voluntary hospital care of veterans at government expense and a discussion of proposed measures to insure adequate hospital care for ex-servicemen are presented by Arden Hardgrove, superintendent of Norton Memorial Infirmary in Louisville and member of the Association's Council on Government Relations.

The first of the three books comprising the 1945 *Hospital Review* — "The Individual Hospital" — has now been distributed to member hospitals. Separately printed articles — "Measuring the Community for a Hospital," and "Organization of the Medical Staff and Governing Board," are available for purchase.

WORK OF MEDICAL DEPARTMENT IN WORLD WAR II

In his biennial report to the Secretary of War, General George C. Marshall, Chief of Staff of the United States Army, paid tribute to the Medical Department for its outstanding work in World War II, as follows:

"The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters and more than 80,000,000 cases passed through the dispensaries and received outpatient treatment. This tremendous task was accomplished by 45,000 Army doctors assisted by a like number of nurses and by more than one-half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"One of the great achievements of the Medical Department was the development of penicillin therapy which has already saved the lives of thousands. Two years ago penicillin, because of an extraordinary complicated manufacturing process, was so scarce the small amounts available were priceless. Since then mass production techniques have been developed and the Army is now using 2,000,000 ampules a month.

"Despite the fact that United States troops lived and fought in some of the most disease-infested areas of the world, the death rate from non-battle causes in the Army in the last two years was approximately that of the corresponding group in civil life — about 3 per 1,000 per year. The greater exposure of troops was counter-balanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, smallpox, and yellow fever and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the non-battle death rate

in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of the troops in this war.

"Insect-borne diseases had a great influence on the course of operations throughout military history. Our campaigns on the remote Pacific islands would have been far more difficult than they were except for the most rigid sanitary discipline and the development of highly effective insecticides and repellents. The most powerful weapon against disease-bearing lice, mosquitoes, flies, fleas and other insects was a new chemical compound commonly known as DDT. In December, 1943, and early 1944, a serious typhus epidemic developed in Naples. The incidence had reached 50 cases a day. DDT dusting stations were set up and by March more than a million and a quarter persons had been processed through them. These measures and an extensive vaccination program brought the epidemic under control within a month. Shortly after the invasion of Saipan an epidemic of dengue fever developed among the troops. After extensive aerial spraying of DDT in mosquito-breeding areas, the number of new cases a day fell more than 80 per cent in two weeks. The danger of scrub typhus in the Pacific islands and in Burma and China was reduced measurably by the impregnation of clothing with dimethyl phthalate.

"The treatment of battle neurosis progressed steadily so that between 40 and 60 per cent of men who broke down in battle returned to combat and another 20 to 30 per cent returned to limited duties. In the early stages of the war less than 10 per cent of these men were reclaimed for any duty.

"The development of methods of handling whole blood on the battlefield was a great contribution to battle surgery. Though very useful, plasma is not nearly as effective in combating shock and preparing wounded for surgery as whole blood. Blood banks were established in every theatre and additional quantities were shipped by air from the United States, as a result of the contribution of thousands of patriotic Americans. An expendable refrigerator was developed to preserve blood in the advanced surgical stations for a period of usefulness of 21 days.

"So that no casualty is discharged from the Army until he has received full benefit of the finest hospital care this Nation can provide, the medical service has established a reconditioning program. Its purpose is to restore to fullest possible physical and mental health any soldier who has been wounded or fallen ill in the service of his country.

"To insure that men are properly prepared

for return to civilian life the Army established 25 special convalescent centers. At these centers men receive not only highly specialized medical treatment, but have full opportunity to select any vocational training or recreational activity, or both, they may desire. Men, for example, who have been disabled by loss of arms or legs are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civil life until they have been given every possible treatment and regained their psychological balance."

TWENTY-SEVEN HUNDRED DOCTORS RELEASED FROM ARMY

During September and the first four days of October, the Army Medical Department has separated 2,700 doctors from the service and by Christmas it is expected that 14,000 doctors will have been separated, Brig. General Raymond W. Bliss, Acting Surgeon General of the Army, stated recently before the House Military Affairs Committee. Through the months of July and August approximately 1,300 doctors were released.

General Bliss pointed out that in proportion to the Army's 45,000 doctors on VE-Day, there are now 43,000 in service, 2,000 of whom are recent graduates of medical schools. With the high hospital load in this country, a large number of doctors are needed to staff hospitals and separation centers, which are now at peak operation. These centers require a total of 2,000 doctors.

Stating the approximate total of patients still in Army hospitals to be 400,000, General Bliss concluded, "You cannot treat patients without doctors . . . According to the laws of Congress you cannot separate men without doctors . . . By Christmas we will have reduced the number of doctors by at least 14,000, which represents more than 30 per cent of the total corps. At the same time, we will continue to meet our first and foremost responsibility to give the American soldier the best medical care that any soldier in any army has ever received."

JOURNAL'S CORRESPONDENT PICTURES HEALTH CONDITIONS IN FRANCE

A picture of health conditions in France during and after the European war is described by the Paris correspondent of *The Journal of the American Medical Association*, who said that "the infant mortality after the winter of 1944 was highest for this century."

In the August 25 issue of *The Journal*, the correspondent said:

"The number of deaths in 1939 exceeded the births by 29,000; the mortality rate was 15.5. Exclusive of

the soldiers who died at the front, the prisoners and the deportees, it reached more than 18.0 in the course of the occupation and decreased to 17.0 in 1943. The infant mortality after the winter of 1944 was highest for this century. The morbidity followed the same trend. New cases of syphilis increased fivefold, typhoid fourfold and diphtheria threefold. Tuberculosis, amounting to 224 deaths per hundred thousand in 1930 and 172 in 1939, attained in 1942 the record figure of 234. There is a deplorable shortage of physicians, a catastrophic deficiency of nurses and social workers and lack of medicines. The number of hospitals is inadequate and their equipment is poor.

"The minister of health has announced projected reforms, but the needs are of such magnitude that best intentions run the risk of only partial fulfillment. . . .

"Medical education is to be improved; the preparation of the physician will be more methodical and better balanced. A more rigid control will replace the liberty formerly enjoyed by the students. A better distribution of physicians over the entire territory is likewise contemplated. At the same time the training of medical aids, particularly of nurses, will be improved, and their social status bettered. Control of physicians created on a new basis, and regulated by the physicians themselves, control of midwives, of dentists and of pharmacists will be the task of the professions themselves. . . .

"A check will be established against the 'fake' pharmaceutical specialties and the 'black market' in medicines."

ARMY DENTISTS FILL OVER SEVENTY-ONE MILLION TEETH

The Army Dental Corps has made 71,500,000 fillings, 16,500,000 extractions, and 2,600,000 dentures for personnel of the Army since Pearl Harbor, according to a report by Major General Robert H. Mills, Director of the Dental Division, Office of The Surgeon General.

As a result of the dental requirements of the early Selective Service program from 1940 to 1941, which required the recruit to have three natural masticating teeth and three serviceable opposing natural incisors, 8.8 per cent of the first 3,000,000 inductees were rejected. Dental defects were the leading cause for rejection, with eye defects second and mental and nervous defects third. The dental requirements for entrance in the Army were lowered twice in 1942 to meet the need for men in military service and finally the only disqualifying factors were severe jaw malformation or malignancies.

The Army Dental Corps accepted full responsibility for rehabilitating these men who could not meet the minimum dental requirements. It was found that average dental requirements for every 100 inductees were about 60 to 80 extractions and a minimum of 240 fillings.

In addition to the rehabilitation of 1,500,000 men for the Army by use of prosthetic appliances, the Army Dental Corps is now working in cooperation with ophthalmological services in methods of fabricating an artificial eye in synthetic resin, of which more than five thousand have been inserted to date. The Dental Service has been active also in making and perfecting the technique associated with plastic ears, noses and chins.

WOMAN'S AUXILIARY : OFFICERS 1944-45

President—Mrs. W. T. Randolph, Winder.
 President-Elect—Mrs. Lucius N. Todd, R. F. D. No. 2, Augusta.
 First Vice-President—Mrs. Edgar H. Greene, 1442 Wesley Road, Atlanta.
 Second Vice-President—Mrs. L. W. Williams, 135 East 45th St., Savannah.
 Third Vice-President—Mrs. Leonard Massengale, Lumpkin.

Recording Secretary—Mrs. Charles Usher, 6 East Liberty St., Savannah.
 Corresponding Secretary—Mrs. Alex Russell, Winder.
 Treasurer—Mrs. Ralph Fowler, Marietta.
 Historian—Mrs. W. W. Puett, Norcross.
 Parliamentarian—Mrs. Lee Howard, 625 East 44th St., Savannah.
 Press and Publicity—Mrs. Charles Daniel, College Park.

AUXILIARY NEWS

To the Auxiliary Members:

May I extend hearty greetings to you at the beginning of our 1945-46 year as an Auxiliary to the Medical Association of Georgia. This war year just past became a peacetime year suddenly, and our hearts were thankful because once again we could envision united families and harmonious living.

This American way of life is the foundation of the ideals of our organization and to preserve it is our duty.

The post-war period brings many problems which will affect our lives, as doctors' wives, and the lives of the lay public. We must affiliate ourselves together with those groups which have the welfare of the people as first interest. Our influence can be far-reaching and we must be adequately prepared to meet whatever demands are made on us through our organization.

Any president likes to think of the steady growth of the Auxiliary she represents and this can best be seen through the membership. This year our State has had a decrease in membership, so begin the year right by enlisting all eligible doctors' wives as Auxiliary members and building up our loss in membership.

The high ideals of our Auxiliary can best be realized through a united effort to enlist every eligible doctor's wife in Auxiliary work, and by giving her constructive work to do.

Let's not overlook *Hygeia* and *The Bulletin* subscriptions and begin immediately to work for the Achievement Award. By following the outlines sent you by your achievements chairman, your Auxiliary may well be the one to win the award. We will meet together in convention in 1946, and this fall of 1945 is not too early to make plans for your exhibits. Redoubled efforts to make this the best convention (in Macon, May 7-10, 1946) ever held may make up for the inspiration lost in not meeting together last year.

Since we represent a noble profession we must prove that we hold to the high ideals and true spirit of medicine that has been manifested by the Association to which we are an Auxiliary.

MRS. W. T. RANDOLPH, *President*.

* * * *

Mrs. B. R. Russell and Mrs. D. M. Bradley were hostesses to the first fall meeting of the

Woman's Auxiliary to the Ware County Medical Society, with Mrs. B. H. Minchew, the president, presiding.

Mrs. Minchew appointed the following committees to serve during the year:

Research and Romance of Medicine—Mrs. W. M. Flanagan, Mrs. W. F. Reavis.

Health Education and Public Relations—Mrs. J. E. Penland, Mrs. B. R. Russell, Mrs. W. L. Pomeroy.

Hygeia—Mrs. W. M. Flanagan.

Press and Publicity—Mrs. W. C. Hafford.

Program and Yearbook—Mrs. A. W. DeLoach, Mrs. W. P. Stoner, Mrs. K. McCullough.

Scrapbook—Mrs. W. C. Hafford and Mrs. L. W. Pierce.

Exhibits—Mrs. R. L. Johnson, Mrs. D. M. Bradley, Mrs. J. R. Gay.

Radio—Mrs. W. L. Pomeroy, Mrs. L. W. Pierce, Mrs. W. M. Folks.

Summer Round-Up—Mrs. K. McCullough, Mrs. H. A. Seaman, Mrs. C. A. Witmer.

The secretary read a communication from the health chairman of Isabella PTA thanking the Auxiliary for the work done in examining the school children.

The officers of the Auxiliary for the ensuing year are:

President—Mrs. B. H. Minchew.

Vice-President—Mrs. K. McCullough.

Secretary—Mrs. W. C. Hafford.

Treasurer—Mrs. J. R. Gay.

Parliamentarian—Mrs. J. E. Penland.

Historian—Mrs. R. L. Johnson.

Honorary Historian—Mrs. J. L. Walker.

* * * *

The Auxiliary to the Georgia Medical Society met at the home of Mrs. R. L. Neville, Savannah, October 5. A letter was read from Mrs. Frank K. Boland thanking the Auxiliary for entertaining her at luncheon. Mrs. Lee Howard called attention to the fact that this was a convention year and asked all members to assist in planning an exhibit.

Mrs. L. W. Williams was appointed as delegate to the Southern Medical Association to meet in Cincinnati in November.

Mrs. Charles D. Center gave an outline of the proposed program for the demonstration of case-finding to be conducted by the Savannah-Chat-

(Continued on page 236)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1944-45

President—Lillian O. Nelson, Atlanta.

First Vice-President—Sister Mary Cornile, Atlanta.

Second Vice-President—Vera Mingledorff, Griffin.

Secretary—Mrs. Esther Watts, Columbus.

Treasurer—Jane Van De Vrede, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys Lilly Garland, Atlanta.

Chairman—State Nursing Council for War Service, Mrs. Lessie Cathier, Atlanta.

Executive Secretary and Chairman—Procurement and Assignment Committee, State Nursing Council for War Service, Mrs. Mildred B. Pryse; headquarters, 875 West Peachtree St., N.E., Atlanta, Phone VERNON 4515.

Executive Secretary—Mrs. Durice Dickerson Hanson; headquarters 131 Forrest Ave., N. E., Atlanta; phone WALNUT 8911; residence, JACKSON 7979.

INDUSTRIAL NURSING IN GEORGIA PROGRESSES

FLO BECK, R.N., *President*
Georgia Association of Industrial Nurses
Chicopee

The Georgia Association of Industrial Nurses is now ending its first year. It was organized Dec. 5, 1944, at our annual meeting in Atlanta. In this year it has expanded by leaps and bounds now covering many local groups in all sections of the State. Our local groups are very stimulating as together we can work out our problems easier, since problems in a given location are usually similar. Within a short while we hope to include all the nurses employed by industry in the State as members. Only by united cooperation and concentrated effort can we maintain and elevate the standards of nurses in industry as well as equalize a standard wage and hour scale. We are a part of the national group — The American Association of Industrial Nurses — who are invaluable to us in our new organization with their advice and suggestions.

The object of our organization is: to stimulate interest in the problems of the industrial nurse and to provide a forum for the discussion of such problems, to give cooperation to individuals and groups interested in the promotion of industrial health, and to aid in the promotion of industrial nurse participation in all nursing activities—local, state, and national.

Our membership is taken from those who are actively employed by industry as well as any person engaged in the management of industry, including sanitarians, safety directors, industrial relation managers, and physicians, and the industrial nurse consultants and directors connected with the divisions of Industrial Hygiene, both State and Federal.

This war has given to industry the impetus that World War I gave to public health. We are now convincing management that a plant can be run more easily, that production can be met with less effort when the employee is

physically well cared for. To the industrial nurse her public health background and knowledge are invaluable. She must teach and live good health. She has little actual acute illnesses to care for, but her daily routine includes a constant and continuous teaching of good health habits, safety precautions, and general prevention of disease.

Besides the routine first aid and redressings, a good industrial nursing program includes the teaching and actual immunization of the employee and his family. She strives to elevate the living conditions of her employees, carefully stressing good water and sewage disposal; she actively participates in the plant's safety program; and teaches classes in nutrition, child care, home nursing, and to the expectant mothers. The industrial nurse should be familiar with all agencies in her community available for aid and assistance to her employees, and work hand-in-hand with her county health center.

With the able assistance of our Division of Industrial Hygiene in the State Department of Public Health, headed by Dr. L. M. Petrie, and Miss Gwen Dekle as nurse consultant, and the Georgia State Nurses' Association with its allied nursing groups standing by to lend a guiding hand, we should and will grow in strength and numbers.

Annual Conference

The Second Annual Conference of the G. A. I. N. was held Nov. 6, 1945, at Atlanta. Completion of organization and election of officers was the main order of business. A report will appear here later.

Library and Reference Material

The Library at State Nursing Headquarters and that of the Georgia Department of Health offer excellent library and reference service for industrial nurses. The magazine, *Industrial Nursing*, the journal of the nurse in industry, is published on the fifteenth of each month by the Industrial Medicine Publishing Company, Chicago. Joanna M. Johnson, R.N., is editor. Subscription is \$1.00 per year in U. S. A., and

(Continued on page 236)

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

EXPANDED TYPHUS CONTROL PROGRAM IN GEORGIA

In view of the increasing incidence of typhus fever in the South Atlantic and Gulf Coast states, the U. S. Public Health Service obtained through Congress appropriations for expanding typhus fever control activities in 9 South Atlantic and Gulf Coast states; namely, Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Texas. Appropriations to the U. S. Public Health Service are for the fiscal year beginning July 1, 1945. As the basis for determining counties or areas in each state for typhus control operations through funds received by the U. S. Public Health Service, 100 counties having the greatest number of typhus fever cases reported for the five-year period 1940 through 1944 were selected.

In the list of 100 counties, as selected and approved by the U. S. Public Health Service for operating under the expanded program, 34 counties are in Georgia; namely, Chatham, Fulton, Bibb, Appling, Dodge, Colquitt, Tift, Bulloch, Dougherty, Decatur, Mitchell, Grady, Early, Glynn, Crisp, Telfair, Terrell, Thomas, Richmond, Seminole, Sumter, Laurens, Screven, Ware, Worth, Coffee, Tattnall, Pierce, Jenkins, Calhoun, Brooks, Toombs, DeKalb and Burke. From the problem that exists in Georgia, the above listed counties are the ones reporting the greatest number of typhus fever cases over the past five-year period. The cases reported range from 51 cases in Burke County (34th county) to 503 cases in Chatham County (No. 1 county). In addition, five additional counties, Schley, Wayne, Evans, Dooley and Peach, have been approved for participation in the expanded program on the basis of the acuteness of the problem during 1944-1945. This makes a total of 39 counties in Georgia that are eligible to receive federal assistance in conducting typhus control measures. However, with budgetary limitation of personnel, equipment and material, programs can only be operated in 34 counties this year. The counties approved by the U. S. Public Health Service serve as a basis for inaugurating the expanded program in Georgia with the provision that after control has been accomplished in any county, or additional funds become available, other counties will be considered for approval by the U. S. Public Health Service on the basis of the acuteness of the typhus fever problem. The criteria for the selection of additional counties are as follows:

1. Counties which reported no cases at all in the five year period 1940 through 1944 may suddenly have a sharp outbreak during 1945 and require some form of emergency program.

2. Counties not justified for operations on the basis of human cases of typhus fever but where investigative studies show a large rat population with a high rate of typhus fever and infected fleas.

Allocation to the states by the U. S. Public Health Service is in the form of personnel, equipment and material. The program is designed principally for DDT dusting as a means of eradicating rat fleas, the vector in transmitting murine typhus fever from rat to man. Also, more permanent control measures are to be applied after initial DDT dusting operations have been put into effect.

DDT has often been referred to as a miracle insecticide. It has been successfully used by the armed forces in the control of insect pests and possibly more noticeably as a typhus control measure (epidemic form) in the delousing of troops in war areas where the disease has been prevalent. Although DDT has proven to be effective in the control of many insect pests, this is the first time that the insecticide has been used on a large scale in the control of murine typhus fever. The DDT used in the Georgia expanded program is in the form of a powder containing 10 per cent DDT and 90 per cent pyrophyllite (talc). Inasmuch as DDT powder has proven to be effective in destroying rat fleas and certain other insect pests, it is believed, therefore, that this insecticide will serve as a typhus control measure. However, since there is no scientific evidence at this time to support this belief, the program must be viewed in the light of an investigative study until such time as scientific information becomes available as to the effectiveness of the insecticide on the control of the disease. It is also assumed, at the present time at least, that the DDT flea dusting is a temporary typhus control measure. It is further believed that it will be necessary to apply the material at frequent intervals. The frequency of applying the material has not been definitely established; however, in the expanded program in Georgia, DDT dusting operations will be repeated at intervals of about every 3 months. DDT dust will be applied to rat runs and rat harborages in business establishments in cities, towns and rural areas, as well as in selected residences and farm units where typhus fever cases have been reported or where typhus infected rats are found through epizootic studies. The reason for this is the limited number of personnel, DDT dust and equipment available and the fact that typhus fever is contracted principally in business establishments rather than in residences.

Immediately following DDT dusting of rat

runs and harborages, rats are to be eradicated by means of poisoning and trapping in all premises previously dusted. This will be effective in destroying the rodent reservoir of murine typhus fever. Subsequently, not only the vector of typhus fever (rat fleas) will be destroyed by DDT, but the rodent reservoir of typhus will be eliminated also.

The allocation of federal assistance by the Georgia Department of Public Health to counties approved for DDT dusting operations is based on the number of typhus fever cases reported to the State Department of Health for the period 1940 through 1944 and the population of the area concerned. Since the allocation of personnel, material and equipment to the Georgia State Health Department is insufficient to carry on the program in the various counties without local participation, it is therefore required that each county participating in this program provide a certain amount of local participation, such as personnel (laborers), office and storage space. Federal assistance will be provided in supplying supervisory personnel, trucks, DDT dust and dusting equipment. The program in general is administered by the Typhus Control Service of the Georgia Department of Public Health with the State Health Department regional health officers, local boards of health and local health departments operating the individual county programs. The Typhus Control Service also serves as technical advisers in local program operations.

Since DDT dusting and rat eradication by means of poisoning and trapping are, so far as known, expedient measures of temporary control of murine typhus fever, they must be applied at periodic intervals indefinitely or until such time as permanent or more lasting control measures can be applied. During DDT dusting operations, assistance will be given to counties and cities for the establishment of permanent rat and murine typhus control measures, consisting of vent-stoppage (ratproofing) of business establishments, rat eradication and refuse collection and disposal. Certain federal participation, such as personnel and equipment, will be provided on a temporary basis for the purpose of organizing local vent-stoppage programs and training local personnel. Vent-stoppage programs are practically self-supporting without any appreciable financial burden to the local government. This is made possible through ordinances and revolving funds provided by the local governments with the owners of buildings and occupants defraying the cost of the work involved. As trained personnel and equipment become available in the State-wide expanded program, plans for establishing permanent rat and murine typhus control measures will be presented to the counties as approved for program operations by the U. S. Public Health Service.

In addition to the control activities, certain investigative studies will be made to determine the effectiveness of various types of control measures, as well as the problem that the disease presents in our State. A special investigative study has been inaugurated in Seminole, Decatur, Grady, Thomas and Brooks counties to determine the effectiveness of certain control measures, such as DDT dusting of rat runs and rat harborages as related to the destruction of rat ectoparasites, as well as other rat eradication measures that may affect the incidence and prevalence of typhus fever in the human and rodent populations. This program will be operated as an addition to the regular State murine typhus control operations as discussed in this paper. The study at the present time will consist essentially of obtaining the following information:

1. Epizootic — Obtaining a quantitative evaluation of the degree of murine typhus infection among rodents and the types and distribution of ectoparasites of rodents.
2. Epidemiologic — Obtaining a quantitative evaluation of actual incidence of murine typhus in humans and the prevalence of typhus complement-fixing antibodies in a representative sample of the human population.
3. Analysis — Obtaining epizootic and epidemiologic information before and after control operations have been carried out so that quantitative comparisons can be made.

It is the plan of the program that the study will require a minimum of two years. It is also quite probable that, as a result of the initial work, additional problems will be demonstrated so that it may become advisable to continue investigations for a period longer than the minimum of two years. The study is being operated jointly by the U. S. Public Health Service, Georgia Department of Public Health, local boards of health and local health departments. The investigative study is organized so that additional studies may be undertaken when deemed necessary, in order to increase our knowledge of the disease problem.

ROY J. BOSTON, *Director,*
Typhus Control Service,
Division of Preventable Diseases.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

**OUR ADVERTISERS HAVE BEEN
GRACIOUS IN THEIR SUPPORT
OF THE JOURNAL
PLEASE REMEMBER THEM WHEN
PURCHASING YOUR SUPPLIES**

NEW GASTRO-INTESTINAL CLINIC AT GEORGIA

The University of Georgia School of Medicine announces the opening of a State Gastro-intestinal Clinic at the Out-Patient Department of the University Hospital, Augusta. This will be a division of the Cancer Clinic of the University Hospital, designed primarily as a diagnostic gastro-intestinal clinic, its main purpose being early diagnosis of cancer of the gastro-intestinal tract. The clinic will be held every Tuesday afternoon, beginning at 2 P.M., except on national holidays. Any one may come, or be sent to the clinic, without appointment if they will be there by 2 P.M. on the clinic day, but it is preferable that the patients have an appointment.

It has been noted that a very large percentage of the patients that arrive at the University Hospital with gastro-intestinal disease are in a very advanced stage of the disease, many arriving too late for any hope of cure. It would seem that the proper handling of cancer of the gastro-intestinal tract is twenty years behind that of cancer of the breast. Twenty years ago it was not uncommon for a lump in the breast to be treated conservatively. Now it is universally accepted that a lump in the breast is cancer until proven otherwise. As a result, the mortality rate of cancer of the breast has been markedly lowered and undoubtedly many cases prevented from ever occurring, whereas persistent gastro-intestinal symptoms without apparent cause beginning in a healthy person in the so-called cancer age have the same serious potentialities as a lump in the breast. They are more often than not treated expectantly and conservatively until evidence of serious constitutional disorder occurs, at which time the cancer has frequently gone too far to cure. This present attitude certainly helps explain why cancer of the stomach accounts for 30 to 35 per cent of all deaths from cancer.

It is not generally known that about 25 to 30 per cent of all carcinomas are primarily in the stomach. The fact that probably only 5 to 8 per cent of these cancers are curable, and that 38,000 people die of cancer of the stomach each year, is largely due to a delay in diagnosis. These figures are given as an illustration of the present situation. Cancers of the large bowel and rectum are also relatively common. Heretofore cancer of the esophagus has carried practically 100 per cent mortality. During the past few years definite progress has been made toward the cure of these cancers. It is hoped that we will be able to get these cases earlier.

With the increase of the average lifetime due to medical advancement, progressively more cases of malignancies of the gastro-intestinal tract will be encountered. Until the public has been educated to the importance of seeking medical attention when they have had any gastro-

intestinal symptom, no matter how minor, for two weeks without any apparent cause, and until the medical profession as a whole feels that these patients are candidates for thorough examinations with the possible diagnosis of cancer considered, until proven otherwise, malignancy of the gastro-intestinal tract will continue to take a high toll of human life, and we will continue to see a large number of patients with hopeless cancer of the gastro-intestinal tract which might have well been cured if diagnosed earlier.

One of the big arguments of both patients and physicians is that patients with comparatively minor complaints feel they cannot afford the expense of a thorough examination. That is one of the reasons for the new clinic. Anyone with gastro-intestinal symptoms will receive an adequate examination without any fee. This includes such special examinations as fluoroscopy, gastric analysis, proctoscopic and sigmoidoscopic examinations, etc.

If the work-up indicates that the patient needs hospitalization, and if he is eligible, he may enter the hospital on the Medical State-Aid or Cancer State Aid programs, depending on whether the condition is malignant or not. If he does not need hospitalization, or does not want to enter here, the clinic will inform his doctor as to the diagnosis and advised care of the patient.

Of course, the major portion of patients with gastro-intestinal symptoms do not have malignancy of the gastro-intestinal tract. A large number of the cases are due to functional disorders, many to non-malignant disease of the gastro-intestinal tract, both of which are causing varying degrees of incapacitation. It is hoped that the clinic may prove to be a help to these patients though its primary purpose is early diagnosis of gastro-intestinal malignancy.

A list of the more common significant gastro-intestinal symptoms has been made for the convenience of the personnel of the Welfare Department:

1. Abdominal discomfort.
2. Disturbances of appetite and slight nausea.
3. Dyspepsia, belching, fullness, food intolerance.
4. Abdominal pain, most significant when associated with food intake or expelling gas or feces.
5. Change in bowel habits — such as diarrhea or constipation.
6. Abnormal stool — such as passage of blood.
7. Nausea, vomiting, regurgitation.
8. Abdominal distention.
9. Any difficulty in swallowing.

For further particulars write the University of Georgia School of Medicine, Augusta.

The Chicago Medical Society will hold its annual clinical conference at the Palmer House, Chicago, March 5, 6, 7, 8, 1946. All physicians are invited to attend this conference and hear the outstanding specialists from all sections of the country discuss subjects of major interest.

NEWS ITEMS

Dr. Cornelius F. Holton, Savannah, was appointed chief surgeon of the Central of Georgia Railway, effective September 1. He succeeds the late Dr. Craig Barrow, who died August 31. Dr. Holton has been a member of the hospital staff of the Central of Georgia since Feb. 15, 1927, and for the past several years has been supervisor of the hospital at Savannah. He brings a broad and varied experience to his new position, including that gained in command of military hospitals on the Mexican border in 1916, and in France during World War I.

As a physician and surgeon, Dr. Holton has won many distinctions in his profession. He is past president of the Georgia Medical Society as well as being past president, and founder, of the Georgia Industrial Surgeons Association, of which he is still secretary and treasurer. He is a member of the Medical Association of Georgia, the American Medical Association, the American Association of Industrial Physicians and Surgeons, and Southern Medical Association. He is also a Fellow of the American College of Surgeons. In Savannah, his home city, he is a member of the staffs of two other hospitals—St. Joseph's and Telfair, as well as being a member of the Board of Trustees of Georgia Infirmary, and during the war served as superintendent of the last named institution in the absence of Dr. T. J. Charlton, on military duty. During the war period he served as a member of the Medical Advisory Board of the State of Georgia for Selective Service, as chairman of the Procurement and Assignment Committee for Chatham County, and as Chief of Medical Services for Civilian Defense.

Dr. L. Minor Blackford, Atlanta, announces the re-opening of his office, 104 Ponce de Leon Avenue, N. E., Atlanta. Practice limited to internal medicine.

Dr. Ira A. Ferguson, Atlanta, having served as commanding officer of the Emory Unit for more than three years, two of which were abroad, has been discharged and has opened his offices for the practice of surgery, 305 Doctors Building, Atlanta.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the hospital dining room, October 11. Dr. L. C. Fischer gave a report on the progress and problems of the hospital. Dr. W. W. Daniel and Dr. George Williams gave a two-year review of cesarean sections performed in Crawford Long Hospital. Discussion was led by Dr. Linton Smith.

Dr. Max Blumberg, Atlanta, announces the opening of his offices, 35 Fourth Street, N. E., Atlanta. Practice limited to internal medicine.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, October 9. Paper: "Therapeutic Goals for Pulmonary Tuberculosis," Dr. Sydney Jacobs, New Orleans.

Dr. Arthur J. Merrill, Atlanta, announces the re-opening of his offices for the practice of internal medicine and cardiology, 35 Fourth Street, N. E., Atlanta.

The Georgia Baptist Hospital staff meeting was held in the Nurses Home Dining Room, Atlanta, October 16. An interesting program was presented.

The Laurens County Medical Society was the guest of the Commanding Officer and his staff at dinner in the Officers' Dining Room of the U. S. Naval Hospital, Dublin, October 3. Program: "Large Bowel Injuries," Lt. (jg) J. M. Vesey. Discussion by Comdr. M. J. Ryan; "A Group of Extremity Fractures," Lt. (jg) W. E. Lee. Discussion by Lt. Comdr. M. B. Roche. Remarks by Captain A. L. Bryan, U. S. N., host.

Dr. C. C. Aven, Atlanta, recently spoke in the series of lectures given the nurses of Warren A. Candler and St. Joseph's hospitals, Savannah, under the sponsorship of the two hospitals and the Chatham-Savannah Tuberculosis Association.

Dr. Paul Rawiszer, Jasper, has moved to Lavonia to practice medicine. Dr. and Mrs. Rawiszer and baby daughter have been extended a cordial welcome to Lavonia.

The Eighth District Medical Society meeting was held at the Y. M. C. A. Auditorium, Waycross, October 9. Meeting called to order by Dr. J. R. Gay, president, Waycross; Invocation, Rev. J. S. Cook, pastor, First Methodist Church, Waycross; Address of Welcome, Dr. B. H. Minchew, Waycross; Response, Dr. W. W. Turner, Nashville. Scientific Program: "Address," Dr. Lombard Kelly, Dean, University of Georgia School of Medicine, Augusta; "Rheumatic Fever," Commander B. E. Goodrich, M. C., U. S. N. R., U. S. Naval Hospital, Dublin; "Headaches," Dr. Earl McKey, Valdosta; "Obstetrics," Dr. Tyrus R. Cobb, Jr., Dublin. Officers: President, Dr. J. R. Gay, Waycross; Vice-President, Dr. J. A. Leaphart, Jesup; Secretary, Dr. G. T. Crozier, Valdosta.

Dr. W. B. Harrison, State Health Officer, who has resided in Gainesville since 1937, has moved to Smyrna, where he will make his home. His office will be at the State Board of Health Office, Atlanta. Dr. W. D. Cagle, former Hall County Health Officer, will serve East and Northeast Georgia from his office at Marietta.

(Continued on page 235)

HELP WANTED

There is a rare accident of labor that is of interest to all physicians in the state doing obstetrics. That accident is acute inversion of the uterus, immediately following labor. It is hoped that as many case reports as possible can be assembled from the physicians of Georgia. Since this accident occurs infrequently and unexpectedly any physician delivering babies may have had a case. If you happen to be one of these will you kindly send a brief history of any such case in your practice to:

Dr. Richard Torpin,
University of Georgia
School of Medicine,
Augusta, Georgia.

The results of the survey will be published in this *Journal*.

Dr. Ralph O. Bowden, prominent young Savannah physician, who entered the Army in 1940 and spent 32 months in the Southwest Pacific, will be the first Savannah physician returning from service in the armed forces, and will soon re-open his offices at Savannah.

Dr. H. W. Scheye, Savannah, resident physician at the Central of Georgia Hospital for the past 5 years, has resigned effective October 1. He is moving to Baltimore, where he will do general practice. Dr. Hayes Cluxton will succeed Dr. Scheye as resident physician at the Central of Georgia Hospital.

Dr. C. L. Ridley, Macon, superintendent of the Macon Hospital, has been elected to the board of trustees of the Georgia Hospital Association. Mr. Fred Walker, of Grady Hospital, Atlanta, was elected president.

Dr. Charles F. Engelking, Dalton, commissioner of public health, has resigned. Effective October 1, he will teach students ear, nose, and throat diseases at the University of Iowa. The loss of Dr. Engelking to the community will result in an immediate curtailment of a number of public health activities in Whitfield County.

Dr. James E. Paullin, Atlanta, has obtained first-hand information on labor and medical conditions in Europe and in the Pacific area. Dr. Paullin visited Tokyo while on the tour.

Dr. W. P. Durham, Eastman, has moved to Americus where he will practice his profession in eye, ear, nose and throat diseases.

Dr. Earl McKey, Valdosta, recently discharged from the U. S. Army, is now practicing medicine in Dr. E. F. Thompson's office on West Central Avenue, Valdosta.

Dr. L. R. Massengale, Lumpkin physician, has accepted an appointment to the position of assistant resident in pediatrics at the University Hospital, Augusta, effective October 1.

The Fulton County Medical Society held its regular dinner meeting at the Academy of Medicine, Atlanta, October 4. Scientific program: "Case Report from St. Joseph's: A Diagnostic Problem," Dr. Sam W. Perry, Dr. Floyd McRae, and Dr. Malcolm P. Mullen; "The Diagnosis and Management of Injuries of the Lower Urinary Tract," Dr. Earl Floyd, Dr. J. L. Pittman, Dr. H. S. Weens, and Dr. Thos. J. Florence. Discussion: Major M. K. Bailey.

Dr. Harry B. Baxley, Donalsonville, has returned from service in the U. S. Army, and will resume the practice of medicine with his office in the Donalsonville Hospital.

Captain William A. Wilkes, Lincolnton, recently discharged from the Armed Forces, where he has served in the European Theater of War, will become a member of the faculty of the University of Georgia School of Medicine, Augusta. He is now in St. Louis where he is taking post-graduate courses.

(Continued on page 236)

ALL PHYSICIANS ARE INVITED TO THE GEORGIA PEDIATRIC SOCIETY THIRTEENTH ANNUAL SCIENTIFIC MEETING ATLANTA, DECEMBER 13, 1945

Afternoon Session, Pompeian Room, Biltmore Hotel
Evening Session, Academy of Medicine

SCIENTIFIC PROGRAM

12:30 P.M.—Luncheon, Pompeian Room, Atlanta Biltmore.

1:45 P.M.—Afternoon Session, Pompeian Room, Atlanta Biltmore.

1. "The Recognition of the Mild Case of Mediterranean (Cooley's) Anemia." Carl H. Smith, M.D., New York, N. Y., Associate Clinical Professor of Pediatrics, Cornell University Medical School.
2. "The Management of Patients with Acute Rheumatic Fever." Helen B. Taussig, M.D., Baltimore, Md., Assistant Professor of Pediatrics, Johns Hopkins University Medical School.
3. "Diagnosis and Treatment of the Intestinal Parasites of the Southern Child." Ernest Carroll Faust, M.D., New Orleans, La., Professor of Parasitology, Acting Head, Department of Tropical Medicine, Tulane University Medical School.

4. Recess.

6:30 P.M.—Buffet Supper, Academy of Medicine, prepared by the wives of the Atlanta pediatricians, under the chairmanship of Mrs. W. W. Anderson, Atlanta.

7:30 P.M.—Evening Session, Academy of Medicine, Main Auditorium.

1. Address of Welcome:
 - a. Edgar D. Shanks, M.D., Atlanta, Secretary, Medical Association of Georgia.
 - b. Joseph C. Massee, M.D., Atlanta, President, Fulton County Medical Society.
2. Response to Address of Welcome:
 - a. Benjamin Bashinski, M.D., Macon.
3. "Acute Infectious Lymphocytosis." Carl H. Smith, M.D., New York, N. Y., Introduction: Joseph Yampolsky, M.D., Atlanta.
4. "Modern Methods of Control of Arthropod-transmitted Diseases in the Southern United States." Ernest C. Faust, M.D., New Orleans, La. Introduction: L. H. Muse, M.D., Atlanta.
5. "The Diagnosis and Treatment of Pulmonary Stenosis and Atresia." Helen B. Taussig, M.D., Baltimore, Md. Introduction: W. W. Anderson, M.D., Atlanta.
6. Adjournment.

OFFICERS OF THE GEORGIA PEDIATRIC SOCIETY

Ruskin King, M.D., Savannah, President
A. M. Johnson, M.D., Valdosta, President-Elect
W. C. Boswell, M.D., Macon, Vice-President
Don F. Cathcart, M.D., Atlanta, Secretary-Treasurer

SCIENTIFIC COMMITTEE

W. W. Anderson, M.D., Atlanta
L. H. Muse, M.D., Atlanta
Joseph Yampolsky, M.D., Atlanta, Chairman

LOCAL ARRANGEMENTS COMMITTEE

Lee Bivings, M.D., Atlanta
T. I. Willingham, M.D., Atlanta
Stephen Redd, M.D., Atlanta, Chairman

Dr. J. D. Martin, Jr., Atlanta, recently discharged from the U. S. Army, after more than two years of foreign service with the Emory Unit, has re-opened his offices for the practice of surgery, 305 Doctors Building, Atlanta.

OBITUARY

Dr. Terrell Eugene Hubert, aged 78, of Meriwether County, retired physician and descendant of a well known Georgia family, died Sept. 21 1945. He was the son of the late James Fannin and Josephine Barksdale Hubert of Warren County. He was graduated from the University of Georgia School of Medicine, Augusta, in 1891. He was a member of Bethel Church. Dr. Hubert was keenly interested in history; he assisted the local D. A. R. members in placing markers on numerous graves of Revolutionary soldiers. He is survived by his wife, the former Elizabeth Stith Myrick; one son, Terrell Hubert, Jr., Washington, D. C.; two daughters, Mrs. William Warren, New Smyrna, Fla.; and Mrs. Louis Balafas, Miami, Fla.; one brother, B. E. Hubert; and three sisters, Mrs. Sarah Ferguson, Miss Katie Hubert, and Mrs. Sue Walker, all of Warren County. Funeral services were held from the Hubert Ancestral Home in Warren County with the Rev. Loran Parker, Methodist circuit pastor, and Rev. Joseph A. Moore officiating. Burial was in the family burial ground.

Dr. James Williamson Maloy, aged 60, of Rhine, prominent and beloved physician, died at his home Sept. 1, 1945. He was the son of the late James W. Maloy and Elizabeth Mizell Maloy of Telfair County. Dr. Maloy graduated from the Hospital Medical College, Eclectic, Atlanta, in 1911, and immediately began the practice of his profession at Rhine. He was a member of the Rhine Baptist Church and a Shriner. He was known over the State for his skill in the practice of medicine, and for his generosity, having been credited with doing more than his share of charity work in connection with his profession. Surviving are his wife, Mrs. Florrie Swymer Maloy; four sons, James W. Maloy III, Albany; Charles O. Maloy, U. S. Army in Germany; Harry Maloy, U. S. N. R., in the Philippines; Beauford W. Maloy, Army Air Corps in the South Pacific; a daughter, Florrie Jean Maloy, Rhine; two grandchildren, Laura Jane and James Oakley Maloy; one brother, D. H. Maloy; and one sister, Mrs. Steve Boney, both of Rhine. Funeral services were held from the Rhine Baptist Church and were conducted by Rev. O. A. Grant, Rev. W. W. Crawford, and Rev. C. L. Nease. Burial was in Bay Springs Cemetery.

Dr. Thomas Winfrey Colvard, aged 76, of Crandall, died at the Hamilton Memorial Hospital, Dalton, Sept. 17, 1945. He practiced medicine throughout Murray and Whitfield Counties until recently despite his advanced age. He was a member of the Whitfield County Medical Society, the Medical Association of Georgia, and the American Medical Association. Funeral services were conducted from his home with the Rev. Charlie Hayes and the Rev. Kirby Parks officiating. Burial was at Cleveland, Tenn.

AUXILIARY NEWS

(Continued from page 229)

ham Health Department in conjunction with the State Health Department and the U. S. Public Health Service, a survey of the whole population of Savannah for the purpose of locating the reservoirs of infections of tuberculosis and syphilis present in our midst. This survey to be conducted in Savannah and Chatham County from October 15 to December 1, 1945.

OKINAWA SNAKES PROVIDE ANTIVENIN

Snakes brought from Okinawa to aid in experiments for the production of American antivenin will be kept on exhibit at Washington Zoo, according to an announcement recently made by the Office of The Surgeon General.

Experiments are under way to determine the effectiveness of American antivenin against the venom obtained from these Okinawa snakes. Analyses are also being made of samples of Japanese antivenin which were captured at Okinawa.

Although this experimental work has not yet been concluded, present indications are that American antivenin should be reasonably effective in the treatment of snake bites on Okinawa.

Several different species of snakes were imported from Okinawa and placed in the Washington Zoo, where venom was taken from them for the work in the biological laboratories. There are no snakes similar to these in America.

Until recently this whole subject was classified as confidential, but now it has been declassified and Washington Zoo authorities have been authorized to exhibit and label the snakes which were placed in their care.

WALTER REED GENERAL HOSPITAL OPENS SWIMMING POOL

The second phase of a three unit reconditioning program was completed recently when a new indoor swimming pool was opened at Walter Reed General Hospital, Washington, D. C.

The primary purpose of the new pool is to provide water therapy for patients. The first unit of the reconditioning program is a gymnasium, and the third is a reconditioning building, which should be completed by the end of this year.

INDUSTRIAL NURSING IN GEORGIA PROGRESSES

(Continued from page 230)

possessions; \$1.25 per year in Canada; \$1.50 per year in other countries. Nurses in industry will want to own a copy of this magazine to add to their reference shelves.

Public Health Nursing and *The American Journal of Nursing* are the two official professional magazines seen on all nursing reference shelves. *Industrial Nursing* magazine joins your other magazines to help keep you professionally wise.

"DO'S AND DON'TS" FOR EYE HEALTH

Do provide proper lighting — without shadows or glare — in the home, school, office, and shop — to avoid eye strain.

Do rest the eyes occasionally by closing them or by looking at distant objects.

Do protect the eyes of infants from exposure to direct sunlight or bright artificial light, and from toys with points or sharp edges.

Do have your child's eyes examined before he enters school and regularly thereafter.

Do have your own eyes examined regularly, whatever your age.

Do consult a competent specialist regarding correction of eye defects, including muscle imbalance, squint, cross eyes, nearsightedness, farsightedness, and blurred vision, and for injured, painful, sore, or diseased eyes.

Do protect your eyes with a shield or goggles of good quality if you work where your eyes are exposed to electric arc rays or sparks, to splashing chemicals, or to flying particles of dust, sand, or metal.

Do not rub your eyes with fingers or soiled handkerchiefs — to do so may rub germs into your eyes.

Do not use towels or wash cloths used by others — they may cause serious eye infections and blindness.

Do not wear colored glasses unless you need them under special circumstances; do not wear colored glasses of inferior quality under any circumstances.

Do not try to diagnose or treat your own eye troubles, and do not wear glasses already made up and sold or displayed on store counters.

Call a doctor immediately if simple measures fail to remove a foreign body in the eye; do not rub the eye — to do so may drive the foreign body deeper into the tissues of the eye and damage or infect the eye.

To remove foreign body, grasp lash of upper lid and pull down over lower lid and then release so that tears may wash foreign body to inside corner of eye where it can be removed easily with corner of sterile bandage — or flush the eye thoroughly with clean, cool water.

Chemicals in the eyes, such as acids, caustics, lime, plaster, cement, etc., should be washed from the eye immediately with very large and repeated quantities of clean cool water before the doctor comes.

SQUIBB RELEASES PENICILLIN SPECIALTIES

Five penicillin specialties are noteworthy among the new products released by E. R. Squibb & Sons, New York. These include tablets for oral use, a sterile suspension to provide slow absorption after intramuscular injection, two ointment preparations, and chewing troches for providing a high salivary concentration of penicillin.

Tablets Penicillin Calcium (Buffered) are compressed, uncoated tablets for oral administration. Each tablet contains 20,000 units of penicillin calcium with 0.5 gram trisodium citrate as a buffer to prevent inactivation of the penicillin by the gastric juice. Each tablet is individually hermetically sealed in aluminum foil. Thus they may be prescribed and dispensed in any desired number without decreasing their protection against loss of potency from moisture. The tablets are packaged in boxes of 25.

Delacillin is a sterile suspension of penicillin calcium in peanut oil and 4.8 per cent bleached beeswax, of a potency of 300,000 units per 1 cc. The relatively high beeswax content (4.8 per cent) was selected to insure slowness of absorption, following intramuscular injection. This, together with the high potency of 300,000 units per 1 cc., assures the physician of the adequacy of a single daily injection in most of his cases. Delacillin is supplied in 1-cc. and 10-cc. vials.

Topicillin Chewing Troches contain 20,000 units of penicillin calcium per troche in a flavored, tinted paraffin base. These troches slowly release their penicillin content into the saliva. The potency of these troches has been made high to avoid any danger of developing penicillin resistance in the invading organism through insufficient dosage and to ensure a high salivary content of the drug that lasts for several hours. Topicillin Chewing Troches are supplied in boxes of 6.

Topicillin Ointment and Topicillin Ointment Ophthalmic contain 1,000 units of penicillin calcium per gram in a stable ointment base of beeswax, peanut oil, petrolatum and anhydrous lanolin. In the case of Topicillin Ointment Ophthalmic the ingredients of the base have been utilized in proportions non-irritating to the delicate tissues for which this ointment is intended. Topicillin Ointment is supplied in tubes containing 14.5 grams; Topicillin Ointment Ophthalmic in tubes of 3.6 grams.

NEW HOSPITAL AUTHORITY

On Oct. 8, 1945, the Hall County Commissioners and City Commissioners of Gainesville, in joint session, created an Hospital Authority in response to a petition signed by all physicians and dentists in the city and county.

After creating the authority they named a Board of Trustees to operate the authority. The board is self-perpetuating, thereby removing all political influence from the board. The following people were named as members of the Board of Trustees: Marshall Stone, Dr. John Burns, and Dr. Lee Rogers for a period of three years; Albert Hardy, Leslie Quinlan and Conrad Ronberg for a period of two years; Mrs. Pierpoint Brown, Charles Young and J. C. Platt for a period of one year.

On Oct. 15, 1945, the board met and perfected its organization. Committees were appointed and instructed to put into effect at once the plans for the construction of a modern two-hundred bed hospital and nurses home. Details are being perfected and it is expected construction will begin early in the spring of 1946.

PHYSICIAN-ARTISTS' PRIZE CONTEST

The American Physicians Art Association, with the cooperation of Mead Johnson & Company, is offering an important series of War (Savings) Bonds as prizes to physicians in the armed services and also physicians in civilian practice for their best artistic works depicting the medical profession's "skill and courage and devotion beyond the call of duty."

For full details, write to the Association's Secretary, Dr. F. H. Redewell, Flood Bldg., San Francisco, Cal., or Mead Johnson & Company, Evansville 21, Ind. Also pass this information on to your physician-artist friends, both civilian and military.

INTERESTED IN CIGARETTE ADVERTISING?

Claims, words, clever advertising slogans do sell plenty of products. But obviously they do not change the product itself.

That PHILIP MORRIS are less irritating to the nose and throat is not merely a claim. It is the result of a manufacturing difference *proved** advantageous over and over again.

But why not make your *own* tests? Why not *try* PHILIP MORRIS on your patients who smoke, and *confirm* the effects for yourself.

* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

PHILIP MORRIS

PHILIP MORRIS & Co., LTD., INC.
119 FIFTH AVENUE, N. Y.

TO PHYSICIANS WHO SMOKE A PIPE:

We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

DEVOTED TO THE WELFARE OF THE MEDICAL ASSOCIATION OF GEORGIA
PUBLISHED MONTHLY under direction of the Council

VOL. XXXIV

Atlanta, Georgia, December, 1945

Number 12

CONCERNING GEORGIA'S MEDICAL NEEDS: A FEW FACTS, FALLACIES AND FIGURES

C. W. ROBERTS, M.D.
Atlanta

That there are gross inadequacies in the delivery of medical and dental services to certain segments of the population none in possession of the facts will deny. The factors responsible are several, and have their respective champions when an effort is made to assign to any one of them a determining role. Two are outstanding. The lack of that degree of health consciousness which leads to eager seeking after medical and dental services already available is, I think, fundamental. The economic barrier is another that must be acknowledged and solved. The availability of an adequate supply of doctors and dentists, believed by some to be a major factor in delinquency, will not alone relieve the situation. Witness the glaring deficiencies that exist in centers of population where the ratio of doctors and dentists to each one thousand of the population is twice that believed to be adequate. The crux of the problem, as suggested earlier, seems to me to be first, lack of consumer demand, and second, ability to buy.

But heavy as are the factors responsible for inadequacy in the urban community, these are known to be markedly aggravated in rural areas. Many studies support the opinion that the number of physicians and dentists in rural communities has been decreasing more rapidly than has the population. Moreover, the age status of the physician increases in like proportion. Young graduates do not go into rural practice in the same proportion as occurred fifty years ago. In 1900 38 per cent of phy-

sicians in the rural areas were over forty-five years of age. In 1925 61 per cent were over forty-five. At the present time even a higher percentage are elderly men and, by the same token, not fully abreast of the times.

One physician or dentist to about 1100 of the population is usually considered adequate from the numerical standpoint. For whatever value statistics are, bearing on this question, it might be of interest to review the ratio of doctor to population in the continental United States since the turn of the century. The dental ratio would no doubt run a close parallel:

Date	Population	No. of	
		Physicians	
1906	85,000,000	121,000	702 people per physician
1910	92,000,000	134,000	686 people per physician
1920	106,000,000	145,000	721 people per physician
1930	128,000,000	155,000	826 people per physician
1940	132,000,000	175,000	754 people per physician

For Georgia comparable figures are as follows:

Date	Population	No. of	
		Physicians	
1938	3,000,000?	1,923	1,560 people per physician
1940	3,123,723	2,814	1,110 people per physician

The 1940 census gave Georgia a population of 3,123,723, about equally divided between urban and rural dwellers. For statistical purposes, people are usually considered to be rural when they live in communities of 2,500 or less. In 1938, with Dr. Alfred A. Weinstein (a prisoner of the Japs since the fall of Bataan), I made a study of the problems of medical care in Georgia which was published in THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, July, 1940. At that time there was a physician-population ratio of one to fifteen hundred sixty. Two years later, and before the war had decimated our ranks, the ratio was one to eleven hundred ten persons.

Out of Georgia's physician population of 2,814 at the war's beginning, it is of interest to record here that not less than 550 or some 20 per cent entered military service, thus imposing an acute physician shortage in this State comparable only to that seen generally over the nation.

It would thus appear that from the standpoint of quantity alone there is in the United States now, and has been since 1900, a ratio of some one doctor to about 750 people, and in Georgia for a comparable period of time, one doctor to about 1200 people. But the immediate future holds stark forebodings. As a result of war dislocations and increased demands growing out of war, a marked reduction in the present physician-dentist population ratio is to be suffered. It is conservatively estimated that more than thirty thousand extra physicians will be needed in the immediate post-war years, as follows: 5,000 for an expanded Navy, 10,000 for the Army, 15,000 for the Veterans' Service, and perhaps other thousands for the needs of the Public Health Service at home and abroad. Other hundreds will be needed for industrial medical services and to man new and expanding hospitals and clinics that all agree are needed and must be provided in the many neglected areas of the country. To provide these physicians there are 69 approved four-year medical schools and 8 approved basic science schools graduating on the accelerated program, which has been in vogue during the war, about seven thousand physicians annually. From this output must be deducted an annual loss of some four thousand by death, leaving some three thousand new physicians per year to be added to the physician population. With this output it will be seen that some ten years will be required to furnish the thirty thousand new physicians urgently needed, not to mention our ordinary peacetime requirements. This is a serious situation which is receiving the careful attention of all concerned. At the present time it appears that an acute physician-dentist shortage will obtain for some years to come.

Quality

It has been said that doctors and dentists are born, not made. This is another way

of declaring that these professions require fine qualities of heart and mind, — that rewards are to be measured not by material gain but by self-sacrificing service. By and large, this concept of duty is the true greatness of these fine servants of humanity, who in large measure are attracted to the professions out of a sincere desire to spend themselves in the common good. If perchance one is thus equipped with an ingrained love of moral and spiritual values, he is ready for the arduous training that these professions require. Nor is his preparation for practice over after graduation. Long and arduous clinical training follows, with frequent post-graduate refresher courses. New methods and new technics require that he remain a student if his patients are to receive the best service of which he is capable. So great have been the discoveries in medical and dental science in the past forty years that his technical training has required frequent overhauling.

A sketchy review will serve to illustrate the herculean task which medical and dental educators have performed in the public interest:

In 1904 the American Medical Association, after having made an exhaustive study of medical education in 1900, established the Council on Medical Education. This was followed in 1910 by the monumental study of medical education in this country by the Carnegie Foundation for the Advancement of Teaching. These studies revealed that only five out of 160 medical schools required any college work for admission. As a matter of fact, many schools of this period were little more than diploma mills, requiring only a few months of residence for the M.D. degree.

Two years later (1912) 85 of the 96 schools required either one or two years of college work as a minimum for entrance. At the present time all of the 69 approved medical schools and the 8 approved basic science schools require a minimum of two years of college work, many requiring three years, and several a college degree. It is of interest also to note that, while college degrees are not widely required for admission to medical schools, 80 per

cent of the graduates at the present time elect to obtain such degrees before making application for admission to medical schools.

In spite of this encouraging picture, one must in truth say that so far as rural medical services in Georgia are concerned the ministry of such well qualified and well trained doctors is not being received. The reason is evident in the statistics quoted, which show that small towns and rural communities in Georgia have a high ratio of older men who received their training before the present high requirements were in force, together with the reluctance with which younger graduates go to the rural communities to practice.

Distribution

It seems logical to conclude that when physicians and dentists are available in numbers sufficient to provide one for each 1,000 to 1,100 of the population (a ratio usually considered to be adequate and present in this country for half a century) there remains to be solved the matter of making medical and dental services available to a large class of economically depressed people, on terms within reach of their substandard incomes. The remedy here would appear to be complex.

A first task is to raise the *per capita* income, together with education, which will increase health demand; a second requirement concerns the question of proper distribution of the available physician and dentist personnel. The Georgia picture with respect to *per capita* income and to physician-dentist distribution is not encouraging. Family income in Georgia (studies by Hosmer and associates at Georgia Tech) are found to fall into five groups:

Group 1—3.3 per cent families making \$5,000 and up with a *per capita* income of \$1,222.

Group 2—4.9 per cent with incomes of \$3,000 to \$5,000, or from \$750.00 to \$1,220 *per person*.

Group 3—8.3 per cent incomes of \$2,000 to \$3,000, or from \$500 to \$750 *per person*.

Group 4—53 per cent with incomes of \$1,000 to \$2,000, or from \$250 to \$500 *per person*.

Group 5—30 per cent with incomes less than \$1,000 or less than \$250 *per person*.

These studies reveal that approximately one-third of the families in Georgia have a *per capita* income of less than \$250 *per annum*.

Distribution of Doctors in Georgia

Two counties of Georgia have no physicians; 39 counties have no dentists; 1 county, 1,000 or less persons *per physician*; 19 counties, 1,000 to 1,999 persons *per physician*; 61 counties, 2,000 to 2,999 persons *per physician*; 76 counties, 3,000 or more persons *per physician*.

Maldistribution of dentists is even more striking, there being only 627 in the State, or one dentist for each 5,000 people. Forty-five per cent of these are found in the Atlanta area, with 24 per cent of the State's population. Together with the above revealing statistics bearing on physician-dentist distribution and *per capita* income, it is only natural to find a similar inadequacy with respect to available general hospital beds in this State. Against the national average of 4.5 beds *per 1,000 population*, we have in Georgia 2.2 beds *per one thousand*. Most of our hospitals (89 per cent) are privately owned and many of them are not approved by a national approving agency. There are six counties which have five beds *per 1,000 population*; 11 counties with three to five beds; 57 counties with less than three beds; and 85 counties have no general hospital beds. It is conservatively estimated that 5,000 additional hospital beds are needed in Georgia to give a minimum of three beds *per 1,000 population*.

Education with respect to the use of hospitals is gradually removing such barriers as popular superstition and prejudice which operate to keep many people, able to provide themselves with hospital treatment, from occupying available beds. As such education progresses, occupancy percentages will inevitably rise. In other words, demand will increase in the group now able to buy hospital services, and pyramid when the low income masses are provided with facilities within their reach.

Georgia suffers from a greater handicap than the lack of health consciousness, if perchance it stems from the same root as superstition and prejudice; namely, the lamentable fact that the yearly *per capita* income is so appallingly inadequate. Without quibbling over the exact figure, native Georgians are prepared to testify to the fact that it is far below the income neces-

sary to the demands of the age in which we live. This unfavorable economic factor means that a high percentage (not less than one-third of the population) of our citizens fall into the indigent or medically indigent group, so far as ability to buy hospital and complete medical and dental services are concerned. These groups, making up a large segment of our citizenry, are unable out of their own resources to secure essential health and hospital care when the need arises. To furnish the minimum of hospitalization needed in this State will require the doubling of our present beds per 1,000 ratio. Certainly on a conservative estimate a building program sufficient to double the present capacity cannot be questioned, even after full use of all private construction is discounted. Thus, in lieu of the less than three beds per 1,000 now credited to Georgia, we need four or perhaps six per 1,000 of population if the needs of all the people are to be met. It is this deficiency problem that faces our profession; in truth, faces all groups concerned with the public welfare. It is our responsibility, along with other groups, to create a scheme of hospital construction which will gain that degree of popular support necessary to their maximum use when the physical facilities have been acquired.

For such support there is need for mobilization of the widest possible community interest in helping the underprivileged citizen needing hospital and medical care to get it. Such is the goal which we as the organized and responsible profession of this State should seek, and I believe it is the goal which equity prescribes.

For such an undertaking in many Georgia communities at least, grants in aid, Federal and/or State, will be needed. Herein, too, lies the answer to the question of unequal distribution of physicians. The problems are alike in their essence, and the remedy for one will be appropriate treatment for the other. But there is an essential prerequisite. I refer to education and understanding, which must here, as has been true always, precede reform. Certainly we have failed thus far to marshal sufficient public support for such community enterprises as are represented by the gen-

eral hospital. When this interest has been secured, the way can be found which will lead to the acquirement of the necessary physical and professional equipment essential in every community to meet the minimum needs. Without such community interest, grants in aid cannot be expected, and even if provided by a paternal state could not be profitably employed. At its center the problem of adequate medical and dental and hospital care for all our people is one which requires leadership at the community and state level. It is devoutly to be hoped that such leadership will be forthcoming and that meetings and programs of the type to be presented at this conference may be repeated until action leading to practical accomplishments is achieved.

26 Linden Ave., N. E., Atlanta.

JOURNAL ASSAILS PROPOSAL TO CHANGE TRADE NAMES OF DRUGS

Several pharmaceutical manufacturers in the United States are planning to market antibiotic preparations, such as penicillin and tyrothricin, under special trade names, and a recent issue of *The Journal of the American Medical Association* warns editorially that the move would only tend to confuse identity of the drugs.

"These agents are among the most active and useful compounds that have ever been developed," the editorial said, adding: "Some of their usefulness will be lost by confusing their identity."

"The phenomenal success of sulfonamide therapy in the United States has been partly due to willingness to make these compounds available under nonproprietary names. When a physician prescribes sulfonamide, sulfathiazole, sulfadiazine or any other sulfonamide he knows exactly what he is prescribing. Such was not and is not now the case in other countries, where the sulfonamides have been offered under a multiplicity of names. What can manufacturers really gain by abandoning the prestige and publicity that have been given to penicillin and attempting *in* lieu thereof to establish new names which mean nothing to the medical profession? If their preparations are misused and if antibiotic therapy does not make the progress for which there is promise, these manufacturers must share the blame. The medical profession may well resent these attempts to muddy the clear waters of scientific advancement to conceal a desire for unwarranted individual profits."

THE SURGERY OF PEPTIC ULCER

JOHN W. TURNER, M.D.

Atlanta

There is no disease the treatment of which is at present more controversial than is the operative treatment of peptic ulcer. However, the opinions expressed here have been arrived at as the result of my experience and may be considered as representative of my best surgical judgment. As the etiology of peptic ulcer is not definitely known, it is impossible to direct therapeutic measures accurately toward the removal of the cause. The efficacy of the treatment must be determined by a careful study of the condition of patients who have been subjected to the different types of treatment. The value of each procedure must be determined by how nearly the results obtained by its use approach the ideal which is sought in the treatment of every disease: to relieve the patient of his symptoms, to prevent any complications incident to the disease or to the treatment, to avoid all sequelae or residual symptoms, to eradicate the cause of the disease, and to return the patient to an active, productive life as soon as possible. In the operative, as well as in the medical treatment of peptic ulcer, the important desideratum — the removal of the cause of the disease — is not accomplished. In this paper it shall be accepted as agreed upon that any operative procedure for gastric or duodenal ulcer must (1) result in a decrease in the hydrochloric acid in the stomach in all cases showing increased or normal acid, (2) establish efficient gastric emptying, with freedom from spasm in the stomach or duodenum; (3) be accompanied by excision of a gastric ulcer; and (4) be associated with ligation of the blood supply of the duodenum in patients suffering from massive hemorrhage from a duodenal ulcer. It is generally agreed that these are essentials which should be accomplished by every operation for the cure of peptic ulcer and those surgical procedures which fail to accomplish these results are unsuitable to the degree of their failure.

Duodenal and gastric ulcers are very different, the differences being inherent or essential, and differences manifested by the effect of the ulcer upon the function of the stomach and duodenum. A duodenal ulcer is essentially benign in that the cells of the first portion of the duodenum do not possess neoplastic potentialities. It is true that adenocarcinoma of the duodenum has been reported, but it is thought that these malignancies have originated in the bile duct or in the pancreas. Every gastric ulcer possesses malignant potentialities, 20 per cent of gastric ulcers being malignant and the stomach being the seat of a greater number of cancers than any other organ.¹ A duodenal ulcer tends to be of a penetrating type and to cause acute perforation of the duodenum; a gastric ulcer, lying over a thicker muscularis, perforates less frequently. Duodenal ulcers are essentially chronic lesions and are habitually obstinate under treatment, tending to persist and to recur. Benign gastric ulcers are acute lesions and respond readily to proper medical treatment. To hemorrhage is an inherent characteristic of both duodenal and gastric ulcers, as some blood is lost from all ulcers. Massive hemorrhage occurs in 37 per cent of gastric ulcers and in 24 per cent of duodenal ulcers.²

In their effect upon function, both duodenal and gastric ulcers prolong the emptying time of the stomach. Duodenal ulcers tend to encroach progressively upon the lumen of the duodenum and to become obstructive. Gastric ulcers rarely become obstructive and in the obstructive instances the obstruction is usually due to spasticity of the gastric musculature.

Based upon these characteristics a duodenal ulcer is essentially a medical condition, becoming surgical only when it becomes penetrating, when it perforates, when hemorrhage occurs, or when it becomes obstructive. Recently, based upon the good results being obtained by partial gastrectomy, intractability with frequently recurring periods of disability has been considered an indication for operation. In such instances, the surgeon should not operate upon his own initiative, but only upon the insistence of the internist in charge of the

patient. On the contrary, a gastric ulcer which is frequently cancerous, although yielding more readily to medical treatment, must be considered inherently a surgical condition and the internist must prove his domain by establishing a rapid cure. Any other attitude toward a gastric ulcer will contribute to a high percentage of inoperability of the malignancies coming to the surgeon. Arbitrarily, one month has been accepted by most medical men and surgeons as the maximum time that a gastric ulcer should be kept upon unsuccessful medical treatment. It has been suggested by Graham⁸ that a gastric ulcer that does not show improvement upon examination by roentgenogram within three weeks should be subjected to surgical treatment.

Acute perforation of an ulcer demands immediate surgical intervention. The surgeon who operates, in determining the proper procedure to employ, should anchor himself with a puritanical conscience to that axiom, so well expressed by Graham,⁴ which governs the principles of surgery in all abdominal emergencies: "Deal in the most simple manner, only with the lesion which creates the hazard to life." With this in mind the surgeon who possesses a responsive conscience will close the perforation in the simplest effective manner possible; clean out gross contamination; place drainage tubes when indicated; and close the abdomen. To attempt, at such a time, procedures directed toward the cure of the ulcer, such as gastro-enterostomy, etc., is not only unsound and meddlesome but is pernicious and leads inevitably to an increased mortality. Perforation of duodenal ulcer occurs usually upon the anterior wall and in its upper half. Perforation of a gastric ulcer occurs upon the anterior wall six or seven times as often as it occurs upon the posterior wall and is most frequently found in the pyloric or prepyloric regions.⁵ Frequently shock and dehydration, factors contributing to the hazard of perforation, must receive attention before the operation is begun. Transfusion of blood from an acceptable donor or the intravenous administration of plasma are the best procedures for combating shock and dehydration. Pain should be relieved by the generous use of morphine.

Massive or recurring hemorrhage from a peptic ulcer is an indication for surgical treatment. The question is whether we should operate during the hemorrhage or wait for the quiescent state. In any event, the patient should be transfused. Transfusion is the most salutary measure available for relief of the anemia and for exerting a favorable influence upon the bleeding. It saves the patient many long weeks of convalescence. If the patient is under fifty years of age and an examination shows his vessels to be elastic and his pressure normal and the hemorrhage is not of massive proportions, it is better to employ conservative measures and to wait, as the mortality from hemorrhage in such cases is between 4 and 5 per cent, which compares favorably with the operative mortality. If, in spite of transfusion and adequate medical treatment, the patient continues for four or more days to bleed constantly or at shortly recurring intervals, and to show a decreasing hemoglobin and red cell count, he should be operated upon. If the patient is above fifty and his pressure is above normal, he has entered an age in which massive hemorrhage from peptic ulcer carries a mortality of 33 per cent. If he continues to bleed for twenty-four hours he should be operated upon. Massive hemorrhage, indicating the erosion of a large vessel, suggests very definitely that the ulcer is located upon the lesser curvature of the stomach or upon the posterior wall of the duodenum. The operation selected in these cases of hemorrhage must be one that will stop the ensuing hemorrhage and will prevent recurring hemorrhages. Ligation of the bleeding vessels is indicated. Gastro-enterostomy is of no value in these cases. The odium which has in the past attached to operative interference in cases of hemorrhage from peptic ulcers has been due to the use of gastro-enterostomy which leaves the bleeding vessel open. Allen² has stated that, "In those instances where bleeding has stopped and the patients have recovered for the time being following gastro-enterostomy, we believe that usually the bleeding would have subsided spontaneously on conservative treatment."

In the bleeding from a duodenal ulcer, it is necessary to ligate the gastroduodenal, the gastro-epiploic, and the pancreaticoduodenal arteries which communicate freely behind the first portion of the duodenum. This leaves the first portion of the duodenum with a blood supply of questionable sufficiency and the ulcer with a supply which is not only insufficient to afford the active blood supply necessary for reparative processes, but also so deficient as to permit further necrosis with secondary hemorrhage. We are thus driven to the consideration of partial gastric resection, and experience has taught that if resection is done it is best to resect at least two-thirds of the stomach. So, in cases of hemorrhage from a duodenal ulcer demanding operation, partial gastric resection offers the best chance of effecting immediate relief and affords also an opportunity for permanent cure.

If the bleeding is from a gastric ulcer, the vessels most commonly involved are the right and left gastric arteries. Occasionally the splenic artery, which has been eroded by a penetrating ulcer of the posterior wall of the lesser curvature, may be responsible for the bleeding. The ulcer should be exposed and the vessels leading into the eroded area should be ligated in healthy tissue. If any difficulty is experienced in locating the ulcer or in ligating the vessels, an incision should be made into the anterior wall of the stomach, the ulcer visualized and the bleeding controlled while the ligatures are being applied. The stomach can then be closed and the patient allowed to recover, the treatment of the persistent ulcer being accomplished at a time of election. In advocating such apparently radical procedures in cases of hemorrhage from a peptic ulcer, I realize that this complication is the most difficult for the internist and for the surgeon, that other procedures have offered no solution, and that the operation necessary for the control of bleeding from a duodenal ulcer is the most difficult in the surgery of peptic ulcer. It is advocated with the belief that such procedures meet the surgical indication and deal directly with the hazard which menaces the patient's life. Gastro-enterostomy in

hemorrhage is haphazard surgery. It subjects the patient to major trauma and ignores the prime indication for surgical intervention; namely, direct control of the bleeding point.

Perforation and hemorrhage are the emergencies which dramatize the life of the ulcer patient. When they appear upon the stage, it is usurped. All other concomitants, all other characters playing a part, become but the supporting cast and are for the time forgotten, as minor characters are not seen when Hamlet speaks. But the ulcer patient cannot be forgotten at other times. Obstructive cases are the bane of the internist and the glory of the surgeon. Duodenal ulcers causing obstruction are ulcers of long standing and are usually found in elderly patients, but may be seen rarely in younger patients. In such young patients the obstruction is not usually from the formation of scar tissue, but has appeared rather suddenly and is due to edematous swelling caused by an acute exacerbation with inflammatory reaction around the ulcer. Obstructive cases of slow development gradually cause a gastritis from food fermentation within the stomach and the cells which normally produce hydrochloric acid become atrophic, thus further decreasing the hydrochloric acid content of the gastric secretion which normally decreases with advancing years. Gastro-enterostomy finds its greatest usefulness, its sublimest justification, in these cases. The elderly patient with an obstructive lesion of his duodenum and with a low acidity may yield to a gastro-enterostomy with the assurance, confidence, and jubilation with which a ship enters its home port, for he shall as certainly find the comfort and contentment from which he has been estranged, as will the sailor find a warm hearth and a happy welcome. The younger patient with an obstructive lesion should be looked upon with suspicion. It should be determined whether the obstruction is due to spasm or to edema rather than to the formation of scar tissue. The patient should be fed through an indwelling duodenal tube for a period of two to three weeks in order to permit the edema to subside and to afford a better opportunity for

an investigation as to the cause of obstruction. The acidity of the gastric secretion should be checked repeatedly preliminary to operation. The elderly patient with obstruction should be fed in the same manner in order to reduce edema and to secure a more favorable operative field. The increase of acidity in the stomach secretion after relief of the obstruction by gastro-enterostomy, with cure of the gastritis, has frequently provoked an increased activity of the ulcer and a reappearance of the symptoms. This has led Allen to advocate partial gastrectomy even in those patients in whom obstruction is the indication for operation.

A penetrating ulcer does not drive us to surgery with the urgency of a perforation or of a hemorrhage, nor does it, like obstruction, invite us with the promise of an immediate and comforting alleviation which banishes the memory of unhappy days. A penetrating ulcer impels the internist to the acceptance of surgical procedures by its constant threat of hemorrhage or of perforation. The imminence of these catastrophes plagues and harries the doctor during the day and frets him at night. Yet, charitably, a penetrating ulcer gives an opportunity for attacking it with the idea of effecting a permanent cure. An ulcer which becomes penetrating indicates the change which has occurred in the pathologic process with a corresponding change in symptoms. The pain which has been of a periodic type, with definite relation to food, becomes continuous and urgent. The patient becomes more apprehensive. Measures upon which the patient relied for relief, become unreliable and without effect. The patient is now suffering from a subacute, localized peritonitis. Such patients should be afforded the relief of a partial gastrectomy with careful attention to the base of the ulcer. No attempt should be made to dissect the ulcer from the pancreas or the liver, if it is firmly attached. In such cases the mucosa can be dissected out leaving the outer layers of the intestine attached to the liver or pancreas.

The uncomplicated gastric ulcer represents a clinical entity of itself. Much needs to be done to improve the results obtained

in these cases. Statistically, the case for partial gastric resection is not difficult to establish, once the internist has considered the case surgical. A gastric lesion bears the onus of malignancy. Twenty per cent of gastric ulcers are malignant. If the ulcer appears after the age of sixty, it is most certainly malignant⁵ and an ulcer on the greater curvature of the stomach is usually malignant. Gastric ulcers having a base with a diameter of two or more centimeters should be considered malignant. Five to 6 per cent of benign gastric ulcers, acting as an exciting factor, afford a site upon which malignancy develops. Six per cent of gastric ulcers are multiple, necessitating resection.⁶ The roentgenologist is usually correct when he makes a definite diagnosis of malignancy, but 20 per cent of the gastric ulcers presenting benign characteristics to the roentgenologist and diagnosed as benign prove to be malignant. Not only is the ulcer susceptible to incorrect interpretation by the roentgenologist, but it is impossible for the surgeon when examining the ulcer in the abdomen and for the pathologist, upon gross examination of the excised specimen, to differentiate with any degree of accuracy between an old indurated benign ulcer and an early malignant one. Excluding those gastric ulcers which demand operation because of the complications of hemorrhage, perforation, or penetration, a large portion of the remainder demand partial resection of the stomach for the removal of the definite threat of malignancy.

It is estimated that 5 to 20 per cent of the patients who have had a gastro-enterostomy develop a gastrojejunal ulcer and that 8 per cent suffer from hemorrhage subsequently to gastro-enterostomy. Perforations occur after gastro-enterostomy in a small percentage of cases.

Apparently partial resection for gastric ulcer should be adopted with great enthusiasm, but there are deterring factors. The mortality in gastro-enterostomy is 1 to 3 per cent. The mortality in partial gastric resection is 3 to 6 per cent. Graham,³ however, has reported a series of 131 cases of partial gastric resection with three deaths. In one of these cases with a diagnosis of

cancer of the bile papilla, Whipple's resection of the duodenum and pancreas was done. If this death be excluded, the mortality in this series is less than 2 per cent. Certainly, such a mortality is not to be achieved generally, but it is my opinion that the mortality of partial gastric resection should not be higher than that of the operation of resection of the ulcer combined with gastro-enterostomy and the minimum requirements of the gastric ulcer patient cannot be met by any less extensive operation.

It has been claimed by the opponents of partial gastric resection that the removal of two-thirds of the stomach is conducive to the development of anemia, but experience with these cases has not justified such an assumption. It is true that there is a small percentage, about 2 per cent, who show a persistent anemia, but this anemia usually yields to iron and the correction of dietary deficiencies.

Originally subtotal gastrectomy was advocated with the belief that it would prevent the development of gastrojejunal ulcers. It has not done this entirely, but the incidence of such ulcers has dropped from 8 to 20 per cent after gastro-enterostomy to 2 to 5 per cent after partial resection. It is generally agreed that the patient who has survived the subtotal gastrectomy is in much better condition than the patient who has had gastro-enterostomy. The higher mortality is, in my opinion, due to a great extent to the fact that partial gastric resection has heretofore been reserved for the more severe cases. With the election of this operation in the indicated cases, as suggested in this paper, the mortality will be very close to that of gastro-enterostomy.

In closing, it should be remarked that peptic ulcer patients, before and after the operation, must be under the observation of an internist for medical supervision, as the ulcer habitus is their garb for life. The tendency in the treatment of peptic ulcer is to adopt a conservative attitude toward the indications for surgery; but, when there are definite indications for surgical intervention, to adopt the more extensive operation of resection as offering the patient the best opportunity for cure. Means,⁷ a

conservative internist, states that some sort of resection is to be preferred to short circuiting operations.

Summary

Gastric and duodenal ulcers are distinct and separate clinical entities.

A duodenal ulcer is essentially a medical condition and must be continued under medical treatment. It should be considered surgical only when complications arise. When operation is demanded partial gastric resection is the operation of choice in all cases except those accompanied by low gastric acidity and obstruction.

Gastric ulcers are essentially surgical lesions and, if resistant to treatment, should be operated upon. Partial gastric resection is the operation of choice in all gastric ulcers.

BIBLIOGRAPHY

1. Walters, Waltman: The Present Status of Gastric Surgery, *J. M. A. Georgia*, 23: 369-377, 1933.
2. Allen, Arthur W.: Acute Massive Hemorrhage from the Upper Gastrointestinal Tract, *Surgery* 2: 5 (Nov.) 1937.
3. Graham, Roscoe R.: Technical Surgical Procedures for Gastric and Duodenal Ulcer, *Surg., Gynec. & Obst.* 66: 269 (Feb.) 1938.
4. Graham, Roscoe R.: The Surgeon's Responsibility in the Treatment of Duodenal Ulcer, *Canad. M. J.* 35: 263-268, 1936.
5. Dible, J. Henry: The Pathology of Gastric Ulcer, *Surgery* 2: 675-691 (Nov.) 1937.
6. Judd, E. Starr: The Surgical Treatment of Lesions of the Stomach and Duodenum, *California & West. Med.* 64: 1 (Jan.) 1936.
7. Means, J. H.: Treatment of Peptic Ulcers, *Surg., Gynec. & Obst.* 66: 264-268 (Feb.) 1938.

HOSPITALS ARE AID TO INTERNATIONAL RELATIONS

The American voluntary hospital is being asked to share the knowledge and experience acquired throughout the war years with the hospitals of rebuilding Europe. The State Department has requested the American Hospital Association to forward the latest technical information and procedures to the health departments of Belgium, France and the central European countries, according to Dr. Malcolm T. MacEachern, chairman of the Association's Council on International Relations.

"With the abrupt withdrawal of the Nazi civil affairs officers, the hospital systems of the formerly occupied countries must have immediate assistance. Our country has an opportunity to perform an outstanding service to the unsettled peoples of Europe. By sharing our knowledge with them, we are contributing to human welfare as well as demonstrating some working practices of the American way of life."

South American countries also have looked to the American voluntary hospital system for advice in planning. By developing institutes on hospital administration, by offering technical assistance in hospital techniques and practices, and by contributing to the philosophy of a growing South American health system, American hospitals are cementing international relations on a professional and social-economic level.

DOCTORS PRESCRIBE MEASURES FOR BETTER DOCTOR-NURSE TEAMWORK

The traditional teamwork of doctors and nurses, though accelerated during the war, must be improved if it is to promote better health for the American people, according to the November 1945 number of the *American Journal of Nursing*.

This is indicated by a recent nation-wide survey of medical opinion on such questions as whether professional nurses have too much or too little education for their duties; whether one, two, or three "levels" of nurses should be educated for different grades of duties; whether doctors and nurses really understand each other's professional viewpoints. Comments are summarized in an article, "The Medical Profession and Nursing," by Edward L. Bernays, counsel on public relations.

Recommendations that nurses let doctors know more specifically what the nursing profession is doing, and how it will advance the patient's health, are made by Mr. Bernays, who conducted the survey for the *American Journal of Nursing*, official organ of the American Nurses' Association, to appraise present-day attitudes of physicians toward the nursing profession.

Army and Navy needs during the war withdrew from civilian life about one-third of all physicians and almost the same proportion of professional nurses, the article points out. Resulting pressures on those who were left led to better teamwork, according to most of the physicians questioned, and to appreciation of nurses' successful adjustment to the speed-up in wartime medicine. "War taught physicians to use nurses more effectively than ever before," said one reply.

A minority believed, on the other hand, that "war brought about a general tension between doctors and nurses by overstraining both groups."

One out of four physicians had no suggestions to make for improving doctor-nurse relations, while almost one in three said they knew too little about the subject for constructive comment. Half of the doctors who expressed themselves believe that some maladjustments exist, due more to misunderstanding or lack of information than to faults of individual practitioners.

Prescribing for the future, physicians recommended three general measures:

1. Exchange of information, speakers, and literature, and greater cooperation, as for instance by sharing responsibility for hospital administration.

2. Changes in education to provide for a definite stratification into such levels as practical nurses, professional nurses for staff duty, and professional nurses for executive or administrative work. Nine out of ten physicians believed that more practical nurses would be needed. Other measures advocated would broaden and "humanize" nursing education, admitted to be well advanced technically; add more physicians

to faculties of schools of nursing; enlarge the psychological and social content of the curriculum; raise general standards of training; and establish refresher courses for older nurses.

3. Better distribution of the costs of nursing care, based on careful study of the economics of nursing. Only one doctor in eight acknowledged the importance of the economic factor, but those who did report a widespread paradox. "Salaries of nurses are too low," wrote one physician, "but the public complains of the cost of special nursing." That the hazards of periodic employment, resulting in a low annual income in spite of good rates per day, are sending many free-lance nurses into the greater security of institutional work, was brought out in a number of replies. Hourly nursing service for patients not needing full-time care was one solution offered.

Extension of the Social Security Act, or enactment of other federal legislation, to include nursing services was predicted by about one-third of those replying. The two-thirds who were against such legislation nevertheless favored inclusion of nursing service in voluntary pre-payment plans.

Postwar plans for health insurance, according to one authority, will incorporate nursing as well as medical care, thus leading to an increased demand for visiting nurses. The need for private duty nurses will decline, in his opinion, but will be balanced by a greater need for public health or visiting nurses.

The article is one of a series through which American nurses are tackling their own "reconversion" problems by appraising relationships between their own profession and major social forces. Important among such forces today, according to the author, are the movement toward government aid in providing health care, and the growth of voluntary health insurance plans.

WOMEN DOCTORS MAKE USE OF TRAINING

A study, reported in the October 13 issue of *The Journal of the American Medical Association*, reveals that of 1,240 women graduates from medical schools, 82 per cent who married have remained in full time medical work.

Florence de L. Lowther, Ph.D., Associate Professor of Zoology, and Helen R. Downes, Ph.D., Assistant Professor of Chemistry, both of Barnard College, New York, found that 1,115 of this number, or 90 per cent, were in full time medical work during 1942-1943.

The study, the authors said, was undertaken to discover what use the women graduates of seven representative Eastern medical colleges during the last 20 years have made of their training. The authors concluded that "the evidence . . . presented indicates that women physicians as a group have amply justified their training and that marriage has had a negligible effect on their professional activities."

THE PRESIDENT'S PAGE

1945 CHRISTMAS GIFT: THE UNITED NATIONS ORGANIZATION

The four past Christmas seasons have come upon a world consecrated to everything else but worshipping the Prince of Peace; there has been no time nor inspiration for celebrating fittingly His birthday. Day-by-day, during these frightful years, distances have shrunk; peoples have become acquainted; the wilds of the world have been invaded; distant seas have become thoroughfares; and here we are all close neighbors with a peace-time Christmas upon us!

So suddenly was war stopped four months ago that we are still amazed! We Americans stand helpless before the world with a vast power that we ourselves are terrified by.

There is little doubt but that if Americans could be granted their dearest wish this Christmas, it would be the assurance that war would never again lay its finger upon our youth, breaking their minds and bodies, leaving older hearts desolate, and wrecking homes. As we gather our young sons and grandsons about us for the Yuletide, warmed by their love and promising abilities, the realization startles us that we are technically still at war; that there is the necessity of a different world relationship and government if we are to keep these youth from being offered up in another decade, or if we ourselves are not to be blown to atoms.

The nearest approach we have ever known to this assurance is vested in the

United Nations Organization with its handbook, The International Charter. We are hardly prepared psychologically or morally for its principles of generosity and world helpfulness. We wish we could keep peace without being bothered about the children of Europe, or the homeless old people all over the world, or the two-thirds of the world's population hungry this winter. But peace, like war, is not so cheap. The price will eat in upon our every individual and community privilege. To make the gift of peace sure, we each must cut deep into our selfish habits of thought and deed; hatreds of all kinds must soften into the energy bombs of forgiveness and world interest. This coveted Christmas gift will have to be nourished and grown by our own sane reasoning and bigness of spirit. Like our little boy who comes to us for money to buy us a Christmas gift, the United Nations stands helpless before the great and small of the world, hoping to be accepted.

The United Nations Relief Rehabilitation Administration, which may not have the teeth of the charter but does hold the life of it, is the instrument which demands the best in us all; and especially does the medical profession share in this responsibility of healing and making stronger the afflicted of the world. The art and science of medicine will not be shared with those alone who can pay for them, but "even unto the least of these." Whoever purposes to establish this attitude in his own life as well as in his community is storing up the most blessed of Christmas gifts — PEACE.

CLEVELAND THOMPSON, M.D.

THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

Devoted to the Welfare of the Medical Association of Georgia

478 Peachtree Street, N. E., Atlanta, Ga.

DECEMBER, 1945

CHRONIC ANXIETY

One of the great medical lessons to emerge from World War II was the need for a more widespread understanding of the psychoneurotic patient. Though many reports were published prior to 1940 about the number of these patients seen in medical practice, most of us were unaware of the true picture until it was unfolded by statistics from the office of the Surgeon General of the Army, and by our own experiences in the service. In the armed forces psychoneurosis was, during the war, the greatest cause of disability and, since the peace, the percentage has increased concomitant with the drop in morale.

The use of the term "psychoneurosis" to cover all non-psychotic functional disorders has been justly condemned. Not only does the term place a "tag" on the individual, but it unconsciously conveys the implication that the psychoneurotic is a weak, cowardly person. It would be better to speak of the "Anxiety State" or "Emotional Instability," for the fact of the matter is most of these patients are suffering from a just cause sufficient to give symptoms.

Functional maladies are usually produced by prolonged exposure to fear, but fear is a human trait common to us all and will produce a breakdown in the most stout-hearted if it continues long enough. The abnormally anxious person develops symptoms as a result of his fear; the symptoms are generally frightening and in turn increase his fear, thus establishing a vicious cycle. Frequently the primary cause disappears but the symptoms remain only to feed the psyche sufficient anxiety to keep the illness operative.

With the better understanding of physiology, the physiology of the autonomic nervous system in particular, many of the symptoms of which these people suffer have been explained. Rage, excitement

and fear frequently produce a distinct hyperglycemia. For example, most football players will show sugar in the urine after an exciting game even though they never left the bench. Conversely, chronic anxiety will often result in a transient hyperinsulinism with all the symptoms of hypoglycemia. During periods of emotional upset, or undue fatigue, yawning and sighing are commonly seen. This results in a gradual reduction of the carbon dioxide content of the blood until the signs and symptoms of tetany appear from a relative alkalosis. Increased tension of the musculature may lead to aching joints, particularly in the region of the occiput. The band-like headaches, so common in these patients, are on the same basis, plus the added vascular constriction.

Thus, with the exception of the hysterical phenomena, such as blindness and paralysis, nearly all the patients with chronic anxiety states have symptoms that are due to physiologic disorders. They suffer untold agonies and deserve our wholehearted sympathy and understanding.

The great temptation in handling these patients is to treat them for a minor organic ailment and explain their troubles on this basis. Vitamins and hormone injections are used far too often and in the end only serve to undermine the confidence of the patient in the physician. Worst of all is to tell the patient nothing is wrong and that his troubles are imaginary. This not only destroys confidence in the physician but also the patient's own self-confidence. Almost any active treatment will give temporary relief. Frequently, a simple explanation of the nature of the symptoms will do a great deal for these patients, but it is only through careful ferreting out of the possible cause of the anxiety that a cure will be effected. If the cause is not found after a few visits it is best to call in a competent psychiatrist.

Unfortunately, the average psychiatrist is too busy with the psychotics to direct his attention to the anxiety states. In addition, there are far too few psychiatrists to handle the supply of patients. Probably the supply of psychiatrists will never reach the demand and the internist must assume part

of the load. With this in mind, it is well for the internist to acquaint himself with the physiology and therapy of chronic anxiety.

BERNARD P. WOLFF, M.D.

TULAREMIA: A WARNING

Hunters who take to the fields during the fall months are warned that 90 per cent of human infections with tularemia result from contact "with the tissues, body fluids or pelts" of rabbits.

Two New Orleans physicians, writing in the October 13 issue of *The Journal of the American Medical Association*, point out, however, that the rabbit isn't the only source of the disease, which is commonly known as "rabbit fever."

The wide variety of animal contacts capable of infecting man with the organism which causes tularemia is not appreciated as highly as it should be, say Roscoe L. Pullen, M.D., and Byron M. Stuart, M.D. Rodents, some birds and even such animals as the dog, cat, coyote, fox, hog and sheep have been found to be sources of the infection.

Drs. Pullen and Stuart, who are from the Department of Medicine, Tulane University of Louisiana School of Medicine, report on 225 cases of tularemia which were observed in the Charity Hospital of Louisiana at New Orleans over a 16 year period.

"In our group 176 patients gave a history of definite contact with rabbits, six to ticks, three to squirrels and one each to mink, raccoon, opossum, dog, cat and rat," the doctors wrote. "In 34 instances a definite contact was not established."

A person suffering from tularemia develops swelling of the skin with the formation of abscesses, swelling of the lymph glands and small spots of infection in the internal organs. There is no specific serum, nor any special treatment for the condition. Sulfonamides have been tried, but without success. "Little information concerning the effectiveness of penicillin is available thus far," the doctors wrote, "but it would appear to be of little value."

The average hospital stay for the 225 tularemia patients was 22.35 days. Seventeen of the 225 patients died from the disease, a mortality of 7.55 per cent. Twelve were Negroes and five were white; nine were males and eight were females.

"It has been our impression," Drs. Pullen and Stuart wrote, "that Negroes manifest less resistance to tularemia than white patients, particularly to the pneumonic forms of the disease. This is further substantiated by the fact that 12 of 93 Negroes (12.9 per cent) died, while only five of 132 white patients (3.8 per cent) failed to recover from the disease. The average age of our patients that died was 33.8 years."

THE INVISIBLE RAY

The roentgenologist is the magician of modern medicine. He is the modern Aladdin, the genii of whose magic bottle is the mysterious x-ray. Truly he looks into the crystal and predicts the future. By his wizardry we may look at the beating heart, the stone in the kidney, the ulcer crater and the distorted physiology of malignancy.

The radiologist will show you, in stereoscopic projection, the mysteries of tuberculosis—the cavity—the infiltration of infection—the healed and calcified battleground. He will point out the amount of necrosis in bone or the extent of the reparative process. He will demonstrate to the surgeon the results of his adjustments of fractures and will predict what the future should bring. One of the most dramatic phases of all surgery is, to us, the setting of a fracture under the fluoroscope.

Within his darkened cave this modern Merlin conjures up more wonders than all the ancient necromancers. He will make visible the passage of opaque fluid through the entire gastro-intestinal tract and indicate any variance from the normal. He will locate with surprising accuracy hidden foreign bodies and will treat with the magic of his ray skin lesions and deep lying malignant processes.

How many things of supreme importance in our daily medical lives do we take for granted. Scarcely ever do we stop and look back over the shoulder to see how far we have come along the highway of progress. It is wise, now and again, to give thought to the things we of this Age of Wonders accept as commonplace. Two things of today are to us of absorbing interest—the perpetual miracle of a radio—the mystery of the x-ray.

Let us pause to pay tribute to this tireless group of scientists—the roentgenologists—those men who stand beside the physician and surgeon and give all out assistance in the problems of disease. These men work at great personal risk—but you will never hear one of them admit it. They are the real magicians of modern medicine—they deal in scientific sorcery.

BERNARD McDUGALL, M.D.

Detroit Medical News,

May 12, 1941.

The Medical Association of Georgia will hold its next annual meeting at the City Auditorium, Macon, May 7-10, 1946.

The JOURNAL would like to record the scientific work of Georgia doctors. It earnestly requests, therefore, that each physician in the State who publishes a contribution in some other medical periodical submit an abstract of the article for these columns.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

T. F. ABERCROMBIE, M.D., *Director*

MANUFACTURERS' HEALTH CLINIC

WINDER, GEORGIA

To bring modern health practices to small industry is a major problem of industrial health today. Large concerns find it comparatively easy to establish and maintain a well-rounded program with full-time physicians, nurses, and technical personnel and equipment. But the costs of such a program and the pressures of the other interests of the physician in private practice introduce many difficulties which management in the small plant frequently finds almost insurmountable.

That industry in Georgia is becoming more conscious of the mutual benefit to be gained through cooperative health programs is evidenced by the organization in Winder, Georgia, of a Manufacturers' Health Clinic. Participating in this program, in coordination with the Barrow County Health Department, and the Industrial Hygiene Division of the State Health Department, are six of the town's manufacturing establishments, the largest of which employs approximately 550 workers, and the smallest, 50. Totalled, the number of employees served through the plan is 1500.

The idea of the clinic, the first of its kind in the state, was conceived in October 1942 by the late Dr. W. L. Mathews, then serving as Barrow County Health Officer. It was to be a program which would embrace both human and economic values. With the help of the County Public Health Nurse, Dr. Mathews arranged a meeting which would organize and promote industrial health work. In attendance were representatives from the State Health Department, the county boards of health and education, and executives from the local industries, which group later established a board of directors who, in turn, elected officers. The six member plants were to finance the clinic cooperatively, each contributing in proportion to its number of employees.

An industrial nurse was employed, and a portion of the fourth floor of the local bank building, converted into equipped clinic rooms, became the hub of the program. On May 20, 1943, the clinic was actually opened.

Originally, routine preplacement and periodic physical examination by the physician of all employees was planned. The physician was to acquaint himself, by periodic plant inspections, with job requirements and hazards in all the plants. Unfortunately, Dr. Mathew's ensuing disability and the acute shortage of physicians in the community rendered this impossible. In its stead, as a temporary measure, a routine physical inspection by the clinic nurse was decided upon. This inspection includes visual and hearing tests, blood tests for syphilis, and notations

of height, weight, pulse rate, urinalysis, and obvious deformities. Such examinations are performed under written standing orders, signed by local physicians. Any abnormality found is referred to the physician of the employee's choice.

Framework of the nursing program is incorporated in the following seven points:

1. Quarterly meetings of nurse with the Board of Directors for report of activities, and discussion of immediate problems and plans for future development.
2. Establishment of routine program whereby health inspections, conferences and redressings are conducted at a specified time of day; this leaving some free time to nurse for tours of the industry, communicative contacts and the like.
3. Training, organization and supervision of first-aid workers. Daily visit to each first-aid station by the nurse.
4. Routine inspection to be made in the industry at stated intervals for the purpose of observing unsafe practices, general house-keeping and hazards, maintenance of rest rooms, etc.
5. Establishment of the cross-index card system for the purpose of adequate follow-up with the workers for correction of remediable defects, redressings and retreatments and individual conferences. A function of the records is to provide a tool for health education with the worker where indicated.
6. Use of County and State Health Department services. For example, maternity classes and well-baby clinics of the County Health Department or the periodic chest x-ray survey of all employees by the State Health Department, with all suspected cases of tuberculosis or other disease followed up by the clinic nurse in cooperation with the Health Department.
7. Plan home visiting by nurse for purpose of contacting individuals with specific needs, and for the purpose of health education of employee and family.

Each year one-hour classes in first-aid instruction are held twice weekly for two months. Each worker completing this course is awarded a highly prized certificate and is placed in charge of a designated number of employees in his factory, and all first-aiders take weekly turns in assisting the nurse during her daily visits to the first-aid stations.

Following the initiation of this effort, the plant owners became interested in the possibilities of such a service and all now have trained first-aid workers. Four of the factories operate well-

(Continued on page 266)

GEORGIA STATE NURSES' ASSOCIATION : OFFICERS—1945-46

President—Mrs. Olive L. Barbin, 957 Russell St., Augusta.

First Vice-President—Sister Mary Cornile, St. Joseph's Infirmary, Atlanta.

Second Vice-President—Vera Mingledorff, Box 335, Griffin.

Secretary—Mrs. Esther Watts, 3304 Fourteenth St., Columbus.

Treasurer—Jane Van De Vrede, R. F. D. 2, Smyrna.

Chairman, Private Duty Section, G.S.N.A.—Mrs. Lilye W. Goodrum Geeslin, 1008 North Ave., N. E., Atlanta.

President—Georgia League of Nursing Education, Julia Miller, Emory University Hospital, Emory University.

President—Georgia State Organization for Public Health Nursing, Mrs. Gladys L. Garland, 701 Glenwood Ave., S. E., Atlanta.

Chairman—State Nursing Council, Mrs. Olive Barbin, 957 Russell St., Augusta.

Executive Secretary, State Nursing Council—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta.

Executive Secretary, Georgia State Nurses' Association, State Headquarters—Mrs. Durice D. Hanson, 131 Forrest Ave., N. E., Atlanta. Phone, WALnut 8911; residence, JACKson 7979.

GEORGIA NURSING NEWS

The 39th Annual Business Session of the Georgia State Nurses' Association and her Private Duty Section; the 19th Annual Session Georgia League of Nursing Education; 20th Annual Session of the State Organization for Public Health Nursing; 2nd Annual Session of the Georgia Association of Industrial Nurses, and the 5th Annual Session of the State Nursing Council for War Service held a joint conference Nov. 5-6, 1945, at the Henry Grady Hotel and Fulton County Academy of Medicine, Atlanta. Miss Lucy Germain, field representative of the *American Journal of Nursing*, and Mrs. Phyllis R. Leonard, executive secretary of the Florida State Nurses' Association, were guests.

Miss Germain conducted a panel on Counseling and Placement Service as established by the American Nurses' Association. Those participating were: Dean William Tate, director of students at the University of Georgia, Athens; Lt. Col. Rubye Bryant, A.N.C., director of nurses Fourth Service Command, Atlanta; Miss Ann Magnussen, director of nursing service, S. E. Area, American Red Cross, Atlanta; Captain E. A. Zellniker, Fourth Service Command Headquarters, Atlanta; Miss Phoebe M. Kandel, professor of nursing education, University of Georgia, Athens, and vice-president of the National League of Nursing Education; Miss Julia Miller, dean of the school of nursing, Emory University, Emory University.

The purpose of the panel was an attempt to give a better understanding of counseling and placement service, including the tentative plan for Georgia, showing how it can assist every nurse to better fit herself for community service and use her skills and special knowledge in such a way as to work harmoniously and happily to meet the ever-changing needs of the program and the people who need adequate nursing care.

Dr. T. F. Abercrombie, director of the Georgia Department of Public Health, presented the health expansion program. This program has been generally endorsed by the nursing groups and is being actively supported.



Mrs. Olive L. Barbin, President

Dean Raimundo De Ovies, rector, St. Philip's Episcopal Church, Atlanta, spoke at a luncheon on November 6, at the Biltmore, stressing the great need for nurses to actively participate in reconversion with greater understanding of the general program. Nurses have the opportunity to give broader service now than ever before.

Special Actions Taken

1. The State Nursing Council for War Service

(Continued on page 274)

DIRECTORY *of the* MEDICAL ASSOCIATION OF GEORGIA for 1945

Names of all Members and Officers are published as corrected by Secretaries of County Societies

APPLING COUNTY

Officers

President.....Overstreet, E. J.
 Secretary-Treasurer.....Holt, J. T.

Members

Branch, W. D., Baxley
 Holt, J. T., Baxley
 Kennedy, F. D., Baxley
 McCracken, H. C., Baxley
 Overstreet, E. J., Baxley

BALDWIN COUNTY

Officers

President.....Sikes, Z. S.
 Vice-President.....Echols, G. L.
 Secretary-Treasurer.....Combs, J. D.
 Delegate.....Cox, C. G.
 Alternate Delegate.....Fulghum, C. B.

Members

Allen, E. W., Milledgeville
 Allen, H. D., Jr., Milledgeville
 Anderson, J. M., U. S. P. H. S., Narcotic Hospital, Lexington, Ky.
 Anderson, S. A., Milledgeville
 Bailey, L. A., Milledgeville
 Binion, Richard, Milledgeville
 Bostick, W. A., Milledgeville
 Bowen, U. S., U. S. Veterans Administration, Los Angeles, Calif.
 Bradford, R. W., Milledgeville
 Clodfelter, Thos. C., Milledgeville
 Combs, Joe D., Milledgeville
 Cox, C. G., Milledgeville
 Echols, Geo. L., Hardwick
 Garrard, J. I., Hardwick
 Griffith, E. F., Eatonton
 Mitchell, Frank, Sr., Milledgeville
 New, J. S., Milledgeville
 Rupp, Alice, Milledgeville
 Schwall, Edward W., Gracewood
 Sikes, Z. S., Milledgeville
 Stewart, J. Benham, c/o R. F. Jordan, Lumber City
 Walker, E. Y., Milledgeville
 Waller, C. P., Milledgeville
 Woods, O. C., Milledgeville
 Yarbrough, Y. H., Milledgeville

BANKS COUNTY

Member

Jolley, J. S., Homer

BARTOW COUNTY

Officers

President.....Howell, S. M.
 Vice-President.....Wofford, W. E.
 Secretary-Treasurer.....Horton, A. L.
 Delegate.....Bradford, H. B.
 Censors: Wofford, W. E.; Bradford, H. B.; Howell, S. M.

Members

Adair, R. E., Cartersville (Hon.)
 Bradford, H. B., Cartersville
 Horton, A. L., Cartersville
 Howell, S. M., Cartersville
 McGowan, H. S., Cartersville

Quillian, Wm. B., Jr., Cartersville
 Stanford, J. W., Cartersville
 Wofford, W. E., Cartersville

BEN HILL COUNTY

Officers

President.....Ware, R. M.
 Vice-President.....Coffee, W. P.
 Secretary-Treasurer.....Bradley, T. E.
 Delegate.....McMillan, J. E.
 Alternate Delegate.....Cornwell, G. K.

Members

Abram, Lewis, U. S. Army
 Bradley, T. E., Fitzgerald
 Coffee, W. P., Fitzgerald
 Cornwell, G. K., Fitzgerald
 Dismuke, H. L., Ocilla
 Harper, A., Wray
 McMillan, J. E., Fitzgerald
 Osborne, L. S., Fitzgerald (Hon.) (Deceased)
 Smith, J. E., U. S. Army
 Ware, D. B., Fitzgerald
 Ware, R. M., Fitzgerald (Deceased)
 Willcox, W. D., U. S. Army
 Willis, G. W., Ocilla

BIBB COUNTY

Officers

President.....Phillips, A. M.
 President-elect.....Kay, J. B.
 Vice-President.....Baxley, W. W.
 Secretary-Treasurer.....Phillips, A. M.
 Delegate.....Fountain, J. A.
 Delegate.....Phillips, A. M.
 Alternate Delegate.....Chrisman, W. W.
 Alternate Delegate.....Weaver, H. G.

Members

Anderson, C. L., 280 College St., Macon
 Anderson, J. C., Persons Bldg., Macon
 Applewhite, J. D., 700 Spring St., Macon
 Barton, Wm. L., Persons Bldg., Macon
 Bashinski, B., 700 Spring St., Macon
 Baxley, W. W., Persons Bldg., Macon
 Bazemore, W. L., 553 Walnut St., Macon
 Boswell, W. Chas., Persons Bldg., Macon
 Camp, J. A., Roberta
 Carey, R. Frank, Board of Health, Macon
 Chrisman, W. W., Doctors Bldg., Macon
 Clay, J. Emory, Clinic Hospital, Macon
 Corn, Ernest, 700 Spring St., Macon
 Dove, W. B., Persons Bldg., Macon
 DuPree, G. W., Gordon
 Edenfield, Robert Watts, 4744 Madeville St., New Orleans, La.
 Farmer, C. H., 553 Walnut St., Macon
 Fountain, J. A., Persons Bldg., Macon
 Gallemore, John L., Perry

Golsan, W. R., U. S. Army, P. O. Box 306, Monroe, N. C.

Goolsby, R. Cullen, Jr., 700 Spring St., Macon

Gostin, B. S., 636 Orange St., Macon (Deceased)

Hall, T. H., Grand Bldg., Macon

Harrold, C. C., 700 Spring St., Macon

Harrold, Thomas, 700 Spring St., Macon

Holmes, J. P., Persons Bldg., Macon

Hurley, T. A., Clinic Hospital, Macon

Johnson, J. E. L., Roberta

Kay, J. B., Byron

Keen, O. F., Persons Bldg., Macon

King, J. L., Box 888, Macon

Mass, Max, 3004 Leland Ave., Chicago 25, Ill.

Massenburg, G. Y., Clinic Hospital, Macon

McAfee, L. C., Clinic Hospital, Macon

McLaughlin, C. K., 703 Bankers Insurance Bldg., Macon

McMichael, V. H., Clinic Hospital, Macon

Meriwether, W. W., Persons Bldg., Macon

Mobley, W. E., 563 College St., Macon

Newman, W. A., 700 Spring St., Macon

Newton, R. G., Persons Bldg., Macon

Patton, Samuel E., Persons Bldg., Macon

Phillips, A. M., 1113 Bankers Insurance Bldg., Macon

Pope, Edgar M., 700 Spring St., Macon

Porch, Leon D., Station Hospital, Camp Claiborne, La.

Rawls, Lewis L., Persons Bldg., Macon

Richardson, C. H., Jr., 700 Spring St., Macon

Richardson, R. W., Persons Bldg., Macon

Ridley, C. L., Macon Hospital, Macon

Rogers, T. E., 120 Clisby Place, Macon

Rozar, A. R., Persons Bldg., Macon

Rubin, Samuel N., Gordon

Siegel, Alvin E., 553 Walnut St., Macon

Smith, Horace D., 10519 Ohio Ave., Los Angeles 25, Calif.

Smith, J. Allen, 700 Spring St., Macon

Suarez, Raymond, Medical Arts Bldg., Macon

Swilling, Evelyn, Medical Arts Bldg., Macon

Thompson, O. R., 700 Spring St., Macon

Walker, D. D., 700 Spring St., Macon

Ware, Ford, Bankers Insurance Bldg., Macon

Weaver, H. G., 700 Spring St., Macon

Weaver, O. H., 700 Spring St., Macon

Williams, W. A., 700 Spring St.,

Macon

Zackery, J. D., Gray

BLUE RIDGE SOCIETY

Officers

President.....Watkins, Ed. W.

Vice-President.....Chastain, W. C.

Secretary-Treasurer.....Watkins, Ed. W.

Members

Burdine, Winston E., Blue Ridge

Chastain, W. C., Ellijay

Edge, H. M., Blairsville

O'Daniel, James F., U. S. Navy

O'Daniel, John Y., Ellijay

Rogers, W. H., Young Cane

Watkins, Ed. W., Ellijay

BROOKS COUNTY

Officers

President.....Jones, A. B., Jr.

Vice-President.....Smith, L. A.

Secretary-Treasurer.....Wasden, Harry A.

Delegate.....Jones, A. B., Jr.

Alternate Delegate.....Smith, L. A.

Members

Groover, M. E., U. S. Army

Jelks, E. L., Quitman (Hon.)

Jones, A. B., Jr., Quitman

Moye, T. R., Quitman (Hon.)

Smith, L. A., Quitman

Wasden, Harry A., Quitman

BULLOCH-CANDLER-EVANS

COUNTIES

Officers

President.....Kennedy, R. L.

Vice-President.....Floyd, W. E.

Secretary-Treasurer.....Simmons, W. E.

Members

Daniel, J. W., Claxton

Deal, B. A., Statesboro

Fletcher, Elizabeth, Statesboro

Floyd, W. E., Statesboro

Kennedy, R. L., Metter

Kennedy, W. D., Metter

McElveen, J. M., Brooklet

Mooney, A. J., Statesboro

Mooney, John, Jr., U. S. Army

Moore, Ed L., Statesboro

Nevil, J. L., Metter

Olliff, H. H., Register

Simmons, W. E., Metter

Stapleton, C. E., Statesboro

Steelsmith, D. C., Statesboro

Stewart, Jas. A., Portal

Watkins, E. C., Brooklet

Whiteside, J. H., Statesboro

BURKE COUNTY

Officers

President.....Hillis, W. W.

Secretary-Treasurer.....Lundquist, W. D.

Delegate.....Byne, J. M., Jr.

Alternate Delegate.....Lowe, W. R.

Members

Bargerion, E. A., Waynesboro

Bent, H. F., Midville

Byne, J. M., Jr., Waynesboro

Daniel, Byron, Sardis (Deceased)

Hillis, W. W., Sardis

Hudson, Jos. H., Gough

Lowe, W. R., Midville

Lundquist, W. D., Waynesboro

McCarver, W. C., Vidette

CARROLL COUNTY

Officers

President.....Powell, J. E.

Vice-President.....Scales, S. F.

Secretary-Treasurer.....Barker, H. L.

Delegate.....Watts, J. W.

Alternate Delegate.....Reese, D. S.

Members

Aderholt, W. A., Carrollton

Barker, H. L., Carrollton

Berry, Robert L., Villa Rica

Hogue, W. L., Villa Rica

Holt, Louis, P. O. Box 265, Carrollton

Nutt, J. J., Route 1, Bowdon

Powell, B. C., Villa Rica

Powell, John E., Villa Rica

Reese, D. S., Carrollton

Roberts, O. W., Carrollton

Scales, S. F., Carrollton

Smith, W. P., Bowdon

Spruell, T. M., Temple (Hon.)

Thomasson, W. E., Carrollton

Watts, J. W., Bowdon

Wilson, L. E., Bowdon

Worthy, W. Steve, Carrollton

GEORGIA MEDICAL SOCIETY

(CHATHAM COUNTY)

Officers

President.....Touchton, G. L.

President-elect.....Long, W. V.

Vice-President.....Redmond, C. G.

Secretary-Treasurer.....Wilson, S. Elliott

Delegate.....Elliott, J. L.

Delegate.....King, Ruskin

Members

Baker, J. O., 126 E. Oglethorpe Ave.,

Savannah

Barrow, Craig, Wormsloe, Rt. 3,

Savannah (Deceased)

Broderick, J. R., 415 Abercorn St.,

Savannah

Brown, C. T., Guyton

Chisholm, J. F., 512 Abercorn St.,

Savannah

Cole, W. A., 32 East Taylor St.,

Savannah

Compton, H. T., 17 E. Jones St.,

Savannah

Crawford, W. B., 14 E. Taylor St.,

Savannah

Dancy, W. R., 102 W. Jones St.,

Savannah

Daniel, J. W., 5 East Jones St.,

Savannah

Daniel, John W., Jr., 5 East Jones St.,

Savannah

Davis, C. L., Hinesville

deCaradeuc, St. J. R., DeRenne Apts.,

Savannah

Demmond, E. C., DeRenne Apts.,

Savannah

Drane, Robert, DeRenne Apts.,

Savannah

Edwards, D. B., 606 Drayton St.,

Savannah

Egan, M. J., 210 E. Liberty St.,

Savannah

Elliott, J. L., 212 E. Huntingdon St.,

Savannah

Egloff, G. E., 402 E. Huntingdon St.,

Savannah

Exlev, H. T., 116 E. Jones St.,

Savannah

Faggart, G. H., 18 W. Oglethorpe

Ave., Savannah

Freeb, H. C., 423 Bull St., Savannah

Gleaton, F. N., 2 East Jones St.,

Savannah

Graham, R. E., 212 East Gaston St.,

Savannah

Ham, O. Emerson, 23 E. Charlton St.,

Savannah

Holton, C. F., DeRenne Apts.,

Savannah

Howard, Lee, DeRenne Apts.,

Savannah

Howkins, J. S., 111 E. Jones St.,

Savannah

Iseman, E., 103 E. Jones St.,

Savannah

Johnson, G. Hugo, Jr., 116 E. Ogle-

thorpe Ave., Savannah

Jones, Jabez, 11 W. Gordon St.,

Savannah

Kelley, A. J., 15 E. Jones St.,

Savannah

King, Ruskin, 10 W. Taylor St.,

Savannah

Lang, G. H., 202 Liberty St.,

Savannah

Lawless, Thomas F., 204 E. Liberty St.,

Savannah

Lee, Lawrence, DeRenne Apts.,

Savannah

Levington, H. L., 209 E. Gaston St.,

Savannah

Long, W. V., DeSoto Hotel, Savannah

Lynn, S. C., 118 E. Jones St.,

Savannah

Maner, E. N., 4 W. Liberty St.,

Savannah

Martin, R. V., 10 W. Jones St.,

Savannah

Massoud, M. A., Pineora

McCarthy, D. J., U. S. Navy

(Deceased)

Neville, R. L., 11 W. Gordon St.,

Savannah

Norton, W. A., 105 E. Oglethorpe

Ave., Savannah

Oliver, R. L., DeRenne Apts.,

Savannah

Olmstead, G. T., 20 E. Taylor St.,

Savannah

O'Neill, J. C., 202 E. Liberty St.,

Savannah

Osborne, E. S., 19 E. Jones St.,

Savannah

Quattlebaum, J. K., 24 W. Gaston St.,

Savannah

Redmond, C. G., 701 Whitaker St.,

Savannah

Redmond, C. R. A., 11 W. Jones St.,

Savannah

Righton, H. Y., 101 E. Waldburg St.,

Savannah

Rosen, Samuel F., 4 E. Jones St.,

Savannah

Schwalb, Otto W., Ft. Lauderdale,

Fla. (Deceased)

Sharpley, H. F., Jr., DeRenne Apts.,

Savannah

Shaw, L. W., 124 E. Oglethorpe Ave.,

Savannah

Shearouse, J. Wm., 14 E. Taylor St.,

Savannah

Smith, P. H., 3 E. Gordon St.,

Savannah

Touchton, G. L., 114 E. Jones St.,

Savannah

Train, J. K., 1107 Bull St., Savannah

Upson, E. T., 201 E. Hall St.,

Savannah

Usher, Charles, 6 E. Liberty St.,

Savannah

Waring, A. J., DeRenne Apts.,

Savannah

Whalen, E. J., 14 W. Jones St.,

Savannah

Williams, L. W., 105 E. Jones St.,

Savannah

Wilson, S. Elliott, 15 E. Gordon St.,

Savannah

Wilson, W. D., 319 Abercorn St.,

Savannah

CHATTOOGA COUNTY**Officers**

President Little, R. N.
 Vice-President Williamson, John T.
 Secretary-Treasurer Hair, W. B.
 Delegate Hyden, Wm. U.

Members

Hair, W. B., Summerville
 Hyden, Wm. U., Trion
 Little, R. N., Summerville
 Williamson, John T., Trion

CHEROKEE-PICKENS COUNTIES**Officers**

President Pettit, J. T.
 Vice-President Jones, R. T.
 Secretary-Treasurer Cornett, D. M.
 Delegate Coker, Grady N.

Members

Brooke, Geo. C., Canton
 Coker, Grady N., Canton
 Cornett, D. M., Canton
 Pettit, J. T., Canton
 Pilcher, J. W., Canton
 Raviszer, Paul, Atlanta
 Vansant, T. J., Woodstock
 Whitfield, T. W., 505 W. Crawford,
 Dalton

CLARKE-MADISON-OCONEE COUNTIES**Officers**

President Dover, Tom A.
 Secretary-Treasurer Florence, Loree
 Delegate Cholston, W. D.
 Alternate Delegate Cabaniss, W. H.

Members

Banister, H. G., Ila
 Bryant, C. H., Comer
 Cabaniss, W. H., Athens
 Dover, Tom A., Athens
 Florence, Loree, Athens
 Gerdine, Linton, Athens
 Gholston, W. D., Danielsville
 Goss, R. M., Athens
 Holliday, J. C., Athens
 Hunnicutt, J. A., Athens
 Moss, W. L., Athens
 Patton, L. S., Athens
 Reynolds, H. I., Athens
 Simpson, John A., Athens
 Veale, Emory O., Arnoldsville
 Westbrook, R. J., Ila
 Wheelchel, G. O., Athens
 Whitley, L. L., Athens

CLAYTON-FAYETTE COUNTIES**Officers**

President Wallis, J. R.
 Vice-President Coleman, Y. R.
 Secretary-Treasurer Busey, T. J.
 Delegate Coleman, Y. R.

Members

Bowling, J. M., U. S. Army
 Busey, T. J., Fayetteville
 Coleman, Y. R., Jonesboro
 Wallis, J. R., Lovejoy

COBB COUNTY**Officers**

President Davis, E. S.
 Vice-President Fowler, A. H.
 Secretary-Treasurer Fowler, R. W.
 Delegate McCall, M. N., Jr.
 Alternate Delegate Mitchell, W. C.

Members

Allen, G. O., Marietta (Deceased)
 Bagley, D. A., Austell
 Banister, C. D., Marietta
 Davis, E. S., Acworth

Ellis, J. W., Kennesaw
 Fowler, A. H., Marietta
 Fowler, R. W., Marietta
 Hagood, G. F., Marietta
 Hagood, M. M., Marietta
 Lester, J. E., Marietta
 McCall, M. N., Jr., Acworth
 Mitchell, W. C., Smyrna
 Perkinson, W. H., Marietta
 Teem, Martin Van B., Marietta
 Welch, L. L., Marietta

COFFEE COUNTY**Officers**

President Quillian, B. O.
 Secretary-Treasurer Johnson, Roy L.

Members

Clark, T. H., Douglas
 Harper, Ege, Wray
 Goodwin, H. J., Douglas
 Harris, Raymond, Regional Hospital,
 Camp Shelby, Miss.
 Johnson, R. L., Douglas
 Quillian, B. O., Douglas
 Shellhouse, L. H., Willacoochee
 Wallace, J. W., Douglas

COLQUITT COUNTY**Officers**

President Brannen, C. C.
 Vice-President Lanier, J. E.
 Secretary-Treasurer Woodall, J. B.
 Delegate Woodall, J. B.
 Alternate Delegate Joiner, R. M.
 Board of Censors: J. B. Woodall, A.
 G. Funderburk and Fverett Daniel

Members

Brannen, C. C., Moultrie
 Brannen, Cecil N., Moultrie
 Chesnutt, T. H., Moultrie
 Daniel, Everett, Moultrie
 Funderburk, A. G., Moultrie
 Gay, Frank M., Moultrie
 Joiner, R. M., Moultrie
 Lanier, J. E., Moultrie
 Lawson, E. L., Moultrie
 McGinty, W. R., U. S. Navy
 Paulk, J. R., U. S. Army
 Slocumh, C. B., Doerun
 Stegall, Robert E., Walnut Ridge, Ark.
 Stone, J. C., Doerun
 Whittendale, W. H., Norman Park
 Withers, S. M., U. S. Army
 Woodall, J. B., Moultrie
 Wright, J. J. C., Doerun

COWETA COUNTY**Officers**

President Tanner, W. H.
 Secretary-Treasurer Cochran, M. F.

Members

Cochran, M. F., Newnan
 Elliott, C. C., Sargent
 Glover, H. C., Newnan
 Hammond, G. W., Newnan
 Jackson, Bruce, Rt. 1, Newnan
 McDonald, R. H., Newnan
 Peniston, Joe B., Newnan
 Tanner, W. H., Rt. 2, Newnan
 Tribble, J. M., Senoia
 Woodroof, Wm. L., Newnan

CRISP COUNTY**Officers**

President Williams, Hiram J.
 Vice-President Adams, Charles
 Secretary-Treasurer Wheelchel, A. J.

Members

Adams, Charles, Cordele
 Dorminy, J. N., Cordele (Hon.)
 Flournoy, H. C., Warwick

Harwell, C. W., Cordele
 McArthur, Chas. E., U. S. Army
 Wheelchel, A. J., Cordele
 Williams, H. J., Cordele
 Williams, L. E., Cordele
 Williams, P. L., Cordele
 Wootten, L. O., U. S. Army

DECATUR-SEMINOLE COUNTIES**Officers**

President Wilkinson, W. L.
 Vice-President Whittle, W. E.
 Secretary-Treasurer Ehrlich, M. A.
 Delegate Wheat, R. F.
 Alternate Delegate Willis, L. W.

Members

Alford, A. E. B., Bainbridge
 Baxley, Harry B., Donalsonville
 Bridges, E. Cleveland, Donalsonville
 Chason, Cordon, Bainbridge
 Ehrlich, M. A., Bainbridge
 Fort, M. A., Bainbridge
 Moseley, E. E., Donalsonville
 Spooner, John L., Donalsonville (Hon.)
 Welch, Carl B., Attapulgus
 Whent, R. F., Bainbridge
 Whittle, Wm. E., Iron City
 Wilkinson, W. L., Bainbridge
 Willis, L. W., Bainbridge

DeKALB COUNTY**Officer**

Secretary-Treasurer,
 Matthews, Lawrence P.

Members

Allen, H. Homer, Decatur Building &
 Loan Bldg., Decatur
 Ansley, H. G., 121 Clairmont Ave.,
 Decatur
 Beck, John E., 113 Clairmont Ave.,
 Decatur
 Blincoe, Homer, P. O. Box 789, Emory
 University
 Duncan, G. A., Masonic Temple,
 Decatur
 Farris, J. D., Dept. of Anatomy,
 Emory University
 Evans, J. R., 120 Clairmont Ave.,
 Decatur
 Matthews, Lawrence P., 1282 S. Ox-
 ford Road, N. E., Atlanta
 McCullough, J. A., 211 Jasmine Rd.,
 Daytona Beach, Fla.
 Smith, W. P., Jr., P. O. Box 125,
 Decatur
 Stewart, Thos. W., Lithonia
 Williams, David C., 216 Sycamore
 Drive, Decatur

DOOLY COUNTY**Officers**

President Daves, V. C.
 Secretary-Treasurer Malloy, M. L.
 Delegate Malloy, M. L.

Members

Bishop, L. H., Unadilla
 Daves, V. C., Vienna
 Davis, E. B., Byromville
 Kitchens, O. W., Byromville
 Malloy, M. L., Vienna
 Mobley, H. A., Vienna (Hon.)

DOUGHERTY COUNTY**Officers**

President Wolfe, David M.
 Vice-President Irvin, I. W.
 Secretary-Treasurer Lucas, I. M.
 Delegate Roberson, Phil E.
 Alternate Delegate Cook, W. S.
 Board of Censors: David M. Wolfe,
 J. C. Keaton and N. R. Thomas

Members

Bacon, A. S., Albany
 Barnett, J. M., Albany
 Cook, W. S., Albany
 Freeman, Alex. R., Albany
 Hilsman, A. H., Albany (Deceased)
 Irwin, I. W., Albany
 Keaton, J. C., Albany
 Knott, Arthur D., Camilla
 Lucas, I. M., Albany
 Neill, F. K., Albany
 Redfearn, J. A., Albany
 Rhyne, Walter P., Albany
 Roberson, Phil E., Albany
 Thomas, N. R., Albany
 Wolfe, David M., Albany

DOUGLAS COUNTY**Officers**

President Bussey, J. G.
 Vice-President Taylor, T. B.
 Secretary-Treasurer Vansant, C. V.

Members

Bussey, J. G., Austell
 Hamilton, R. E., Douglasville
 Taylor, T. B., Douglasville
 Vansant, C. V., Douglasville

ELBERT COUNTY**Officers**

President Ward, C. A.
 Vice-President Johnson, W. A.
 Secretary-Treasurer Johnson, A. S.

Members

Bailey, D. V., Elberton
 Gaines, T. H., Elberton
 Johnson, A. S., Elberton
 Johnson, J. E., Elberton (Hon.)
 Johnson, J. E., Jr., Elberton
 Johnson, W. A., Elberton
 Mattox, B. B., Elberton (Hon.)
 Smith, A. C., Elberton
 Smith, F. A., Elberton
 Thompson, D. N., Elberton
 Ward, G. A., Elberton

EMANUEL COUNTY**Officers**

President Chandler, J. H.
 Vice-President Youmans, S. S.
 Secretary-Treasurer Smith, D. D.
 Delegate Chandler, J. H.
 Board of Censors: J. H. Chandler,
 S. S. Youmans and D. D. Smith

Members

Chandler, J. H., Swainsboro
 (Deceased)
 Griffin, R. B., Swainsboro
 Smith, D. D., Swainsboro
 Youmans, S. S., Swainsboro

FLOYD COUNTY**Officers**

President Cheney, G. W. H.
 Vice-President Moss, Thos. H.
 Secretary-Treasurer Smith, Inman
 Delegate Harbin, William, Jr.
 Alternate Delegate Mull, J. H.
 Board of Censors: R. C. Maddox, W.
 A. Sewell and William Harbin, Jr.

Members

Banister, W. G., Rome
 Battle, Lee H., Rome
 Borders, W. A., Armuchee
 (Deceased) (Hon.)
 Bosworth, Edward, Rome
 Chandler, J. L., Rome
 Cheney, G. W. H., Rome
 Connor, J. C., Cave Springs
 Dawson, Harry, Shannon
 Dellinger, A. H., Rome

Elmore, B. V., Rome
 Carrard, J. L., Rome
 Gilbert, Warren M., U. S. Army
 Green, Gordon, U. S. Army
 Harbin, B. Lester, U. S. Army
 Harbin, R. M., Jr., Rome
 Harbin, William Jr., Rome
 Harris, C. I., Jr., U. S. Army
 Jenkins, Oliver W., Lindale
 Johnson, Ralph N., U. S. Army
 Lewis, W. H., Rome
 Maddox, R. C., Rome
 McCall, J. T., Rome
 McCall, John T., Jr., U. S. Army
 McCord, M. M., Rome
 McCord, Ralph B., Rome
 Methvin, S. R., Lindale
 Moore, Clifford, Lindale
 Moss, T. H., Rome
 Mull, J. H., Rome
 Norton, Robert F., Rome
 Routledge, A. F., Rome
 Sewell, W. A., Rome
 Smith, G. B., Rome
 Smith, Inman, Rome
 Webbe, R. S., Rome

FORSYTH COUNTY**Officers**

President Bramblett, R. H.
 Vice-President Mashburn, Marcus
 Secretary-Treasurer Lipscomb, W. E.
 Delegate Mashburn, Marcus

Members

Bramblett, R. H., Rt. 1, Cumming
 Lipscomb, W. E., Cumming
 Mashburn, Marcus, Cumming

FRANKLIN COUNTY**Officers**

President Brown, Stewart D.
 Vice-President Poole, E. T.
 Secretary-Treasurer Smith, B. T.

Members

Brown, Stewart D., Royston
 McCrary, H. L., Royston
 McCrary, J. O., Royston
 Parker, G. M., Carnesville
 Poole, E. T., Lavonia
 Ridgway, Robert E., Royston
 Smith, B. T., Carnesville

FULTON COUNTY**Officers**

President Massee, Joseph C.
 President-elect Goodwyn, Thos. P.
 Vice-President Read, Joseph C.
 Secretary-Treasurer Johnson, McClaren
 Delegate Greene, Edgar H.
 Delegate Rushin, Chas. E.
 Delegate Fitts, John B.
 Delegate Clifton, Ben H.
 Delegate Williams, Geo. A.
 Delegate Turner, John W.
 Delegate Hamff, L. Harvey
 Alternate Delegate Hallum, Alton V.
 Alternate Delegate Willingham, T. I.
 Alternate Delegate Cofer, Olin S.
 Alternate Delegate,

Brawner, Jas. N., Jr.
 Alternate Delegate Harrison, M. T.
 Alternate Delegate Allen, Eustace A.
 Alternate Delegate,
 Dimmock, Avary M.
 Alternate Delegate Johnson, McClaren
 Alternate Delegate Floyd, Earl

Members

Abbott, Osler A., 516 E. Wesley Road,
 N. E., Atlanta
 Abercrombie, T. F., Georgia Dept. of
 Public Health, Atlanta

Adams, C. M., 23 W. Paces Ferry
 Road, Atlanta (Deceased)
 Adams, C. R., 840 Gordon St., S. W.,
 Atlanta
 Adams, H. M. S., Candler Bldg.,
 Atlanta
 Agnor, Elbert B., Medical Arts Bldg.,
 Atlanta
 Aiken, W. S., First National Bldg.,
 Atlanta
 Akin, John T., Jr., Medical Arts
 Bldg., Atlanta
 Alden, H. S., Medical Arts Bldg.,
 Atlanta
 Allen, Eustace A., Medical Arts Bldg.,
 Atlanta
 Allison, Cordon G., Grant Bldg.,
 Atlanta
 Anderson, A. Burton, U. S. Army
 Anderson, W. W., 478 Peachtree St.,
 N. E., Atlanta
 Archer, George F., U. S. Army
 Armstrong, Edward S., 1161 Ponce de
 Leon Ave., N. E., Atlanta
 Armstrong, T. B., Candler Bldg.,
 Atlanta
 Armstrong, W. B., 478 Peachtree St.,
 N. E., Atlanta
 Arnold, W. A., Peters Bldg., Atlanta
 Arp, Chas. Reymond, U. S. Navy
 Artaud, F. E., P. O. Box 234, New
 Port Richey, Fla. (Asso.)
 Arteaga, Oliver, U. S. Army
 Arthur, J. F., 157 Forrest Ave., N. E.,
 Atlanta
 Askev, Rufus A., 10 Pryor St. Bldg.,
 Atlanta
 Atkins, F. M., 478 Peachtree St.,
 N. E., Atlanta
 Aven, C. C., Medical Arts Bldg.,
 Atlanta
 Ayer, G. D., 152 Forrest Ave., N. E.,
 Atlanta
 Ayers, A. J., Medical Arts Bldg.,
 Atlanta
 Baggett, L. G., 478 Peachtree St.,
 N. E., Atlanta
 Bailey, M. K., Medical Arts Bldg.,
 Atlanta
 Baird, Jas. B., Jr., P. O. Box 8,
 Station C, Atlanta
 Baird, J. Mason, U. S. Navy
 Baird, N. W., 541 Lee St., S. W.,
 Atlanta
 Baker, Luther P., Peters Bldg.,
 Atlanta
 Baker, W. Pope, Valdosta (Asso.)
 Ballenger, E. G., Healey Bldg.,
 Atlanta (Deceased)
 Ballenger, W. L., 478 Peachtree St.,
 N. E., Atlanta
 Bancker, E. A., Jr., 478 Peachtree
 St., N. E., Atlanta
 Barfield, Hugh H., 1317 S. Orange St.,
 Ocala, Fla.
 Barfield, J. R., 592 Clifton Road, N. E.,
 Atlanta (Asso.)
 Barnett, Crawford F., 478 Peachtree
 St., N. E., Atlanta
 Barnett, S. T., Jr., U. S. Naval Hos-
 pital, Memphis, Tenn.
 Bartholomew, R. A., 1259 Clifton Rd.,
 N. E., Atlanta
 Bateman, Needham B., Jr., Candler
 Bldg., Atlanta
 Beall, Chas. R. F., 478 Peachtree St.,
 N. E., Atlanta
 Beard, Donald E., 1410 Peachtree St.,
 N. E., Atlanta

- Beasley, B. T., Hurt Bldg., Atlanta
 Beeson, Paul B., Grady Hospital, Atlanta
 Benson, H. Bagley, Medical Arts Bldg., Atlanta
 Benson, Marion T., Jr., U. S. Navy
 Benson, M. T., Medical Arts Bldg., Atlanta
 Berry, Maxwell R., Jr., 478 Peachtree St., N. E., Atlanta
 Bishop, Everett L., Medical Arts Bldg., Atlanta
 Bivings, F. Lee, 20 Fourth St., N. W., Atlanta
 Bivings, Wm. Troy, 756 Cypress St., N. E., Atlanta (Hon.)
 Blackford, L. Minor, 104 Ponce de Leon Ave., N. E., Atlanta
 Blackman, W. W., 418 Capitol Ave., S. E., Atlanta
 Blalock, Frank A., 150 Anderson Ave., S. W., Atlanta
 Blalock, John C., Medical Arts Bldg., Atlanta
 Blalock, Tully T., Boston
 Blandford, W. C., Candler Bldg., Atlanta
 Bleich, J. K., 778 Brookridge Drive, N. E., Atlanta
 Blumberg, Max M., 35 Fourth St., N. E., Atlanta
 Boland, Chas. G., 157 Forrest Ave., N. E., Atlanta
 Boland, F. Kells, 478 Peachtree St., N. E., Atlanta
 Boland, Frank K., 478 Peachtree St., N. E., Atlanta
 Boland, Joseph H., 478 Peachtree St., N. E., Atlanta
 Boling, Edgar, 478 Peachtree St., N. E., Atlanta
 Bowcock, Chas. M., 831 Woodlawn Ave., Dallas, Texas (Hon.)
 Bowcock, Harold M., 987 Rupley Dr., N. E., Atlanta (Asso.)
 Bowdoin, C. D., Georgia Dept. of Public Health, Atlanta
 Boyd, B. Hartwell, 56 Fifth St., N. E., Atlanta
 Boyd, M. L., 563 Capitol Ave., S. W., Atlanta (Hon.)
 Boynton, C. E., 26 Linden Ave., N. E., Atlanta (Hon.)
 Bovnton, Estelle P., 26 Linden Ave., N. E., Atlanta
 Brannen, Cliff, Grant Bldg., Atlanta
 Brannon, E. S., 16-F Pine Circle, N. E., Atlanta
 Brawner, A. F., 478 Peachtree St., N. E., Atlanta
 Brawner, J. N., 2800 Peachtree Road, N. E., Atlanta
 Brawner, J. N., Jr., 262 W. Wesley Road, N. W., Atlanta
 Brawner, L. E., Medical Arts Bldg., Atlanta
 Bridges, G. J., Long Island College Hospital, Brooklyn, N. Y.
 Brown, Robert L., Robert Winship Clinic, Emory University Hospital, Emory University
 Brown, S. Ross, 1000 Peachtree Battle Ave., N. W., Atlanta
 Brown, S. T., Medical Arts Bldg., Atlanta
 Brown, S. Y., 56 Fifth St., N. E., Atlanta
 Bullard, T. P., Palmetto (Deceased)
 Bunce, Allen H., 139 Forrest Ave., N. E., Atlanta
 Burch, J. C., 150 Anderson Ave., S. W., Atlanta
 Burgess, Taylor S., U. S. Navy
 Burke, B. Russell, 478 Peachtree St., N. E., Atlanta
 Bush, O. B., Candler Bldg., Atlanta
 Butner, J. H., U. S. Army
 Byram, James H., Grand Theater Bldg., Atlanta
 Byrd, Edwin S., 1027 Oxford Road, N. E., Atlanta
 Byrd, T. Luther, 478 Peachtree St., N. E., Atlanta
 Calhoun, F. P., 478 Peachtree St., N. E., Atlanta
 Calhoun, F. P., Jr., 478 Peachtree St., N. E., Atlanta
 Callahan, Alston, U. S. Army
 Callaway, J. T., 1514 Rogers Ave., S. W., Atlanta (Asso.)
 Camp, R. T., Fairburn
 Camp, W. R., Fairburn (Hon.)
 Campbell, J. L., 478 Peachtree St., N. E., Atlanta
 Campbell, J. L., Jr., U. S. Army
 Campbell, W. E., Jr., Medical Arts Bldg., Atlanta
 Candler, Robert W., 2498 Montview Drive, N. W., Atlanta
 Cantor, I. B., Medical Arts Bldg., Atlanta
 Carothers, Jas. B., Grand Theatre Building, Atlanta (Deceased)
 Case, Iverson C., Jr., 35 Linden Ave., N. E., Atlanta (Asso.)
 Cathcart, Don F., 478 Peachtree St., N. E., Atlanta
 Catron, I. T., Candler Bldg., Atlanta (Hon.)
 Champion, W. L., 478 Peachtree St., N. E., Atlanta (Hon.)
 Chappell, Amey, 11 Seventeenth St., N. E., Atlanta
 Childs, J. R., Medical Arts Bldg., Atlanta
 Childs, L. W., Lake Kerr, Fla. (Asso.)
 Christopher, F. E., Hurt Bldg., Atlanta
 Clark, J. J., 478 Peachtree St., N. E., Atlanta
 Clarke, M. L. B., U. S. Army
 Clav, Grady E., Medical Arts Bldg., Atlanta
 Clifton, Ben H., 478 Peachtree St., N. E., Atlanta
 Cline, B. McH., Grand Theater Bldg., Atlanta
 Cochran, George H., U. S. Army
 Cofer, Olin S., 478 Peachtree St., N. E., Atlanta
 Cohen, Isodore, U. S. Army
 Cole, G. C., 538 Eighth St., N. W., Atlanta (Asso.)
 Coleman, Reese C., Jr., U. S. Army
 Collier, T. J., 1781 Peachtree Road, N. E., Atlanta
 Collingsworth, A. M., Candler Bldg., Atlanta
 Colvin, E. D., 1259 Clifton Road, N. E., Atlanta
 Colvin, E. S., Healey Bldg., Atlanta
 Combs, J. A., 478 Peachtree St., N. E., Atlanta
 Cooke, Virgil C., Healey Bldg., Atlanta
 Copeloff, M. B., Mortgage Guarantee Bldg., Atlanta
 Coppedge, W. W., 106 N. East Point St., East Point
 Corley, F. L., Peters Bldg., Atlanta
 Coslett, Floyd W., 2066 Cottage Lane, N. W., Atlanta
 Cousins, W. L., Candler Bldg., Atlanta
 Cowan, Z. S., Grand Theater Bldg., Atlanta
 Cowart, Chas. T., U. S. Navy
 Crawford, Clyde L., Medical Arts Bldg., Atlanta
 Crawford, H. C., 478 Peachtree St., N. E., Atlanta
 Crawford, J. H., Grant Bldg., Atlanta
 Cross, John B., Medical Arts Bldg., Atlanta
 Crowe, Wm. R., Medical Arts Bldg., Atlanta
 Curtis, Walker L., College Park
 Dabney, W. C., 73 Eleventh St., N. E., Atlanta
 Daly, Leo P., Medical Arts Bldg., Atlanta
 Daniel, Chas. H., College Park
 Daniel, W. W., 743 W. Peachtree St., N. E., Atlanta
 Daniels, Chas. W., 760 W. Peachtree St., N. W., Atlanta
 Davenport, T. F., 104 Ponce de Leon Ave., N. E., Atlanta
 Davis, J. E., Grand Theater Bldg., Atlanta
 Davis, S. C., 35 Linden Ave., N. E., Atlanta
 Davis, Wm. B., U. S. Army
 Davison, Hal M., 478 Peachtree St., N. E., Atlanta
 Davison, T. C., 478 Peachtree St., N. E., Atlanta
 Denmark, Leila D., 1051 Hudson Dr., N. E., Atlanta
 Denton, J. F., 478 Peachtree St., N. E., Atlanta
 Dew, J. Harris, U. S. Army
 Dickson, Roger W., 33 Ponce de Leon Ave., N. E., Atlanta
 Dimmock, Avary M., Hurt Bldg., Atlanta
 Dobes, Wm. L., 478 Peachtree St., N. E., Atlanta
 Dobson, J. L., 126 Forrest Ave., N. E., Atlanta
 Dorough, W. S., U. S. Navy
 Dougherty, Mark S., U. S. Navy
 Dowman, Chas. E., Medical Arts Bldg., Atlanta
 Duncan, B. C., Sweetwater, Tenn. (Asso.)
 Duncan, John B., 478 Peachtree St., N. E., Atlanta
 Durham, Wm. P., Frostproof, Fla.
 DuVall, W. B., 26 Linden Ave., N. E., Atlanta
 Eberhart, Chas. A., U. S. Army
 Edgerton, M. T., Candler Bldg., Atlanta
 Edwards, Wm. T., Jr., U. S. Navy
 Elkin, Dan C., Ashford General Hospital, White Sulphur Springs, W. Va.
 Equen, Murdock, 144 Ponce de Leon Ave., N. E., Atlanta
 Eskridge, Frank, 744 W. Peachtree St., N. E., Atlanta
 Estes, H. G., 478 Peachtree St., N. E., Atlanta
 Etheridge, Wm. N., 33 Maddox Drive, N. E., Atlanta
 Ezzard, Thomas M., Roswell
 Fancher, J. K., 478 Peachtree St., N. E., Atlanta

- Fanning, O. O., Grand Theater Bldg., Atlanta (Hon.)
- Felber, Ernest, 157 Forrest Ave., N. E., Atlanta
- Ferguson, Ira A., 478 Peachtree St., N. E., Atlanta
- Filip, Alexander J., Healey Bldg., Atlanta
- Fincher, Ed F., Medical Arts Bldg., Atlanta
- Fischer, L. C., 35 Linden Ave., N. E., Atlanta
- Fitts, John B., Medical Arts Bldg., Atlanta
- Flowers, A. P., Medical Arts Bldg., Atlanta
- Floyd, Earl H., 478 Peachtree St., N. E., Atlanta
- Fort, Chester A., Jr., U. S. Army
- Fort, Lynn, Jr., 921 Myrtle St., N. E., Atlanta
- Foster, K. E., College Park
- Foster, Maude E., Hurt Bldg., Atlanta
- Fowler, C. Dixon, U. S. Navy
- Fowler, M. F., 478 Peachtree St., N. E., Atlanta
- Frierson, Norton, Jr., U. S. Army
- Fuller, Geo. W., 478 Peachtree St., N. E., Atlanta
- Funke, John, 712 Durant Place, N. E., Atlanta
- Funkhouser, W. L., 33 Ponce de Leon Ave., N. E., Atlanta
- Fuqua, E. E., 986 Hemphill Ave., N. W., Atlanta (Deceased)
- Gabler, Regina, 717 Grant Bldg., Atlanta
- Gallis, Anthony H., Atlanta
- Garner, John P., 794 Springdale Rd., N. E., Atlanta
- Garner, J. R., 4 Hunter St., S. E., Atlanta (Hon.)
- Garver, Carl G., U. S. Navy
- Garvin, Wm. H., Jr., 17 Prescott St., N. E., Atlanta (Asso.)
- Gay, J. G., 104 Ponce de Leon Ave., N. E., Atlanta
- Gay, T. B., 151 Ponce de Leon Ave., N. E., Atlanta
- Geeslin, Laurence E., Camp Blanding, Fla.
- Germain, A. H., Candler Bldg., Atlanta
- Gershon, Nathan I., U. S. Navy
- Gibson, Eugene F., College Park
- Gibson, Ira Malcolm, 2431 Westminster Way, N. E., Atlanta
- Gibson, Sam T., U. S. Navy
- Giddings, C. G., 478 Peachtree St., N. E., Atlanta (Hon.)
- Giddings, Glenville, 478 Peachtree St., N. E., Atlanta
- Gilbert, W. L., Georgian Terrace Hotel, Atlanta (Hon.)
- Glenn, Wadley R., Crawford W. Long Mem. Hospital, Atlanta
- Glisson, Chas. S., Medical Arts Bldg., Atlanta
- Goldsmith, L. H., Athens
- Goldsmith, Wm. S., P. O. Box 3122, Daytona Beach, Fla. (Hon.)
- Goodpasture, W. C., Medical Arts Bldg., Atlanta
- Goodwyn, Thos. P., 478 Peachtree St., N. E., Atlanta
- Graydon, E. L., 1305 Prairie Ave., Houston, Tex. (Asso.)
- Green, A. J., Union City
- Green, Samuel, Peters Bldg., Atlanta
- Greene, Edgar H., 478 Peachtree St., N. E., Atlanta
- Greenberg, Irving L., U. S. Army
- Gershon, Nathan I., U. S. Naval Hospital, Charleston, S. C.
- Griffin, Claude, Medical Arts Bldg., Atlanta
- Grimes, Wm. H., 1259 Clifton Road, N. E., Atlanta
- Grove, L. W., Medical Arts Bldg., Atlanta
- Guthrie, N. J., Medical Arts Bldg., Atlanta
- Hackney, J. F., Health Dept., City Hall, Atlanta
- Hailey, Howard, 478 Peachtree St., N. E., Atlanta
- Hailey, Hugh, 911 Medical Arts Bldg., Atlanta
- Hall, C. E., Jr., 478 Peachtree St., N. E., Atlanta
- Hall, O. D., Georgia Baptist Hospital, Atlanta
- Hallum, Alton V., 478 Peachtree St., N. E., Atlanta
- Hamff, Leonard Harvey, 478 Peachtree St., N. E., Atlanta
- Hamm, Wm. G., U. S. Navy
- Hanner, Jas. P., U. S. Army
- Harris, J. Frank, Medical Arts Bldg., Atlanta
- Harrison, M. T., Medical Arts Bldg., Atlanta
- Hathcock, Wm. C., Medical Arts Bldg., Atlanta
- Hauck, A. E., U. S. Army
- Henry, Jas. Lamont, U. S. Army
- Hess, George, 505 McDonough Blvd., S. E., Atlanta
- Heyman, Albert, Grady Hospital, Atlanta
- Hewell, Guy C., 33 Ponce de Leon Ave., N. E., Atlanta
- Heyser, D. T., 190 Boulevard, S. E., Atlanta
- Highsmith, E. D., 622 Moreland Ave., N. E., Atlanta (Hon.)
- Hines, John H., 922 W. Peachtree St., N. E., Atlanta
- Hines, Jos. H., 922 W. Peachtree St., N. E., Atlanta
- Hobby, A. Worth, 478 Peachtree St., N. E., Atlanta
- Hodges, Fred B., Jr., 478 Peachtree St., N. E., Atlanta
- Hodges, J. H., Hapeville
- Hodges, W. A., 492 Page Ave., N. E., Atlanta (Asso.)
- Hodgson, F. G., Medical Arts Bldg., Atlanta
- Hoffman, Byron J., 768 Juniper St., N. E., Atlanta
- Holden, F. G., Medical Arts Bldg., Atlanta
- Holloway, Geo. A., U. S. Navy
- Holmes, Champ H., P. O. Box 365, Atlantic Beach, Fla.
- Holmes, W. R., 478 Peachtree St., N. E., Atlanta
- Hope, H. F., 3193 Roswell Road, N. W., Atlanta
- Hoppe, L. D., Medical Arts Bldg., Atlanta
- Horton, B. E., Grand Theater Bldg., Atlanta
- Howard, Charles, U. S. Navy
- Howard, P. M., College Park
- Howell, H. Stacy, 478 Peachtree St., N. E., Atlanta
- Hudson, P. L., Trust Co. of Ga. Bldg., Atlanta
- Huguley, G. P., 126 Forrest Ave., N. E., Atlanta
- Hull, Marion McH., 573 W. Peachtree St., N. E., Atlanta (Hon.)
- Hunter, Conway W., 770 Cypress St., N. E., Atlanta
- Hutchins, J. T., 1704 Lakewood Ave., S. W., Atlanta
- Ivey, John C., 743 W. Peachtree St., N. E., Atlanta
- Jackson, Zack W., 478 Peachtree St., N. E., Atlanta
- Jacobs, John L., 2883 Andrews Dr., N. W., Atlanta
- Jenkins, M. K., 248 Randolph St., N. E., Atlanta
- Jennings, Jas. L., 1704 Lakewood Ave., S. E., Atlanta
- Jernigan, H. W., U. S. Navy
- Jernigan, Sterling H., 57 Sixth St., N. E., Atlanta
- Johnson, J. G., 478 Peachtree St., N. E., Atlanta (Hon.)
- Johnson, McClaren, 478 Peachtree St., N. E., Atlanta
- Johnson, Trimble, 478 Peachtree St., N. E., Atlanta
- Jones, Edward G., U. S. Army
- Jones, Eugenia Cuvillier, 478 Peachtree St., N. E., Atlanta
- Jones, Jack W., Medical Arts Bldg., Atlanta
- Kane, Thos. M., Grand Theater Bldg., Atlanta
- Kelley, L. H., 478 Peachtree St., N. E., Atlanta
- Kelley, W. A., 478 Peachtree St., N. E., Atlanta
- Kemper, C. G., 478 Peachtree St., N. E., Atlanta
- Key, Claude T., 78 Ellis St., N. E., Atlanta
- Kirkland, Spencer A., 478 Peachtree St., N. E., Atlanta
- Kite, J. H., 478 Peachtree St., N. E., Atlanta
- Klugh, Geo. F., 139 Forrest Ave., N. E., Atlanta
- Kraft, H. N., Candler Bldg., Atlanta
- Krugman, Philip I., 65 Sheridan Dr., N. E., Atlanta (Asso.)
- Lake, Wm. F., 35 Linden Ave., N. E., Atlanta
- Lamm, J. Herman, 1203 Medical Arts Bldg., Atlanta
- Landham, J. W., 139 Forrest Ave., N. E., Atlanta
- Lange, John H., U. S. Army
- Laws, G. L., Medical Arts Bldg., Atlanta
- Lee, C. A., Citizens & Sou. Bank Bldg., Atlanta
- Leadingham, R. S., Medical Arts Bldg., Atlanta
- Leonard, Wm. P., 312 Medical Arts Bldg., Atlanta
- Letton, A. H., U. S. Navy
- Levin, Harold B., U. S. Army
- Levin, Jack M., 10 Pryor St. Bldg., Atlanta
- Lipscomb, Laura A., 478 Peachtree St., N. E., Atlanta
- Lipton, Harry R., 573 W. Peachtree St., N. W., Atlanta
- Logue, R. Bruce, U. S. Army
- Lokey, H. M., Medical Arts Bldg., Atlanta

- Longino, D. R., 1344 Lanier Blvd., N. E., Atlanta
- Longino, T. D., 386 Ponce de Leon Ave., N. E., Atlanta (Hon.)
- Lownace, Mason I., 478 Peachtree St., N. E., Atlanta
- Lower, Emory G., 745 Marietta St., N. W., Atlanta
- Lunsford, Guy G., Georgia Department of Public Health, Atlanta
- Lyon, G. T., 745 Marietta St., Atlanta
- Mahon, Robert F., Atlanta
- Malone, O. T., 157 Forrest Ave., N. E., Atlanta
- Manget, J. D., 118 Forrest Ave., N. E., Atlanta
- Manget, Jas. D., Jr., U. S. Army
- Martin, A. J., U. S. Army
- Martin, Elisabeth, 756 Cypress St., N. E., Atlanta
- Martin, J. D., Jr., 478 Peachtree St., N. E., Atlanta
- Martin, J. J., 478 Peachtree St., N. E., Atlanta
- Martin, W. O., Jr., 478 Peachtree St., N. E., Atlanta
- Meshburn, C. M., 139 Forrest Ave., N. E., Atlanta (Deceased)
- Massee, Joseph C., 478 Peachtree St., N. E., Atlanta
- Matthews, O. H., 139 Forrest Ave., N. E., Atlanta
- Matthews, Thos. V., 478 Peachtree St., N. E., Atlanta
- Matthews, Warren B., 478 Peachtree St., N. E., Atlanta
- Matthews, Wm. H., U. S. Army
- Maulding, Homer R., Medical Arts Bldg., Atlanta
- Mauldin, John T., Grady Hospital, Atlanta
- Maxwell, Edgar J., Jr., Georgia Baptist Hospital, Atlanta (Asso.)
- McAliley, R. G., 104 Ponce de Leon Ave., N. E., Atlanta (Deceased)
- McAllister, J. A., 126 Wesley Ave., N. E., Atlanta
- McCay, C. C., 1st National Bldg., Atlanta
- McClure, Robert E., 478 Peachtree St., N. E., Atlanta
- McCord, J. R., 50 Armstrong St., N. E., Atlanta
- McCorkle, Robert L., 157 Forrest Ave., N. E., Atlanta
- McDaniel, J. G., U. S. Navy
- McDonald, H. P., Healey Bldg., Atlanta
- McDonald, Lewis H., U. S. Army
- McDonald, Paul, Bolton
- McDougall, J. C., Medical Arts Bldg., Atlanta
- McDougall, W. L., 478 Peachtree St., N. E., Atlanta
- McFloy, J. D., U. S. Army
- McGee, Roy W., County Health Dept., Courthouse, Atlanta
- McGinty, A. Park, U. S. Navy
- McLoughlin, Christopher J., Medical Arts Bldg., Atlanta
- McNiece, Estelle, 11 Seventeenth St., N. E., Atlanta
- McRae, Floyd W., Medical Arts Bldg., Atlanta
- Merrill, Arthur J., 35 Fourth St., N. E., Atlanta
- Mickel, Carey A., Jr., 742 Yorkshire Rd., N. E., Atlanta
- Miller, H. C., 478 Peachtree St., N. E., Atlanta
- Miller, Linus J., U. S. Army
- Mims, F. C., Mortgage Guarantee Bldg., Atlanta
- Minnich, Fred R., 478 Peachtree St., N. E., Atlanta
- Minnich, Wm. R., Newton D. Baker Hospital, Martinsburg, W. Va.
- Minor, Henry W., 157 Forrest Ave., N. E., Atlanta
- Mitchell, Chas. H., U. S. Army
- Mitchell, Marvin A., 478 Peachtree St., N. E., Atlanta
- Mitchell, Wm. E., U. S. Navy
- Moncrief, W. M., Jr., 151 Ponce de Leon Ave., N. E., Atlanta
- Monfort, John M., 478 Peachtree St., N. E., Atlanta
- Morris, J. L., Alpharetta
- Morris, S. L., Jr., 573 W. Peachtree St., N. W., Atlanta
- Mosley, Hugh G., Mortgage Guarantee Bldg., Atlanta
- Mullen, Malcolm P., 478 Peachtree St., N. E., Atlanta
- Murray, Samuel D., 2479 Alton Road, N. W., Atlanta
- Muse, L. H., Medical Arts Bldg., Atlanta
- Myers, Guy A., U. S. Army
- Myers, Martin T., Medical Arts Bldg., Atlanta
- Nabors, Dewey T., Candler Bldg., Atlanta
- Nall, James D., 500 Chestnut St., N. W., Atlanta
- Nardin, Gene, 1323 Ponce de Leon Ave., N. E., Atlanta
- Neel, M. M., Georgia Department of Public Health, Atlanta
- Neely, F., Levering, Medical Arts Bldg., Atlanta
- Nellans, C. T., 118 Forrest Ave., N. E., Atlanta
- Nelson, Richard M., Connally Bldg., Atlanta
- Neuffer, Frank, U. S. Army
- Newberry, R. E., Candler Bldg., Atlanta
- Nicolson, Wm. P., Jr., 478 Peachtree St., N. E., Atlanta
- Nippert, Philip H., U. S. Navy
- Noel, Malcolm E., 300 Capitol Ave., S. E., Atlanta
- Norris, Jack C., U. S. Naval Hospital, Brooklyn, N. Y.
- Norwood, Samuel W., U. S. Army
- Nucholls, John B., U. S. Navy
- Olds, Bomar, 26 Linden Ave., N. E., Atlanta
- Oppenheimer, R. H., 50 Armstrong St., S. E., Atlanta
- Osborne, V. W., 427½ Moreland Ave., N. E., Atlanta
- Owensby, N. M., Medical Arts Bldg., Atlanta
- Paine, C. H., 123 Forrest Ave., N. E., Atlanta
- Parham, LeRoy G., Medical Arts Bldg., Atlanta
- Parker, Francis P., 1685 W. Wesley Road, N. W., Atlanta
- Parks, Harry, Candler Bldg., Atlanta
- Paty, Robert M., Emory University, Emory University
- Paullin, James E., Medical Arts Bldg., Atlanta
- Payne, R. Floyd, State Tuberculosis Sanatorium, Alto
- Peck, Robt. E., 478 Peachtree St., N. E., Atlanta
- Pendergrast, Wm. J., 478 Peachtree St., N. E., Atlanta
- Pentecost, M. P., 478 Peachtree St., N. E., Atlanta
- Perry, Samuel W., 478 Peachtree St., N. E., Atlanta
- Person, W. E., Candler Bldg., Atlanta
- Petrie, Lester M., Georgia Department of Public Health, Atlanta
- Phillips, H. S., U. S. Navy
- Pierotti, Julius V., 478 Peachtree St., N. E., Atlanta
- Pittman, J. L., Jr., 478 Peachtree St., N. E., Atlanta
- Poer, D. Henry, Headquarters, 5th Service Command, Ft. Hayes, Columbus 18, Ohio
- Powell, Charles C., U. S. Army
- Powell, V. E., U. S. Army
- Pruitt, M. C., Medical Arts Bldg., Atlanta
- Quillian, G. W., Woodstock, Va. (Asso.)
- Quillian, W. E., Medical Arts Bldg., Atlanta
- Ragan, W. E., Jr., 25 Third St., N. E., Atlanta
- Rawiszer, Hubert, Candler Bldg., Atlanta
- Rayle, Albert A., 478 Peachtree St., N. E., Atlanta
- Read, Ben S., Medical Arts Bldg., Atlanta
- Read, Joseph C., Medical Arts Bldg., Atlanta
- Redd, S. C., 157 Forrest Ave., N. E., Atlanta
- Reed, Clinton, Candler Bldg., Atlanta
- Reynolds, H. L., 211 The Prado, N. E., Atlanta
- Rhodes, C. A., 126 Forrest Ave., N. E., Atlanta
- Rice, Keith C., Medical Arts Bldg., Atlanta
- Richardson, Jeff L., 118 Forrest Ave., N. E., Atlanta
- Ridley, H. W., Grant Bldg., Atlanta
- Rieser, Charles, U. S. Army
- Riley, J. G., Forsyth Bldg., Atlanta
- Riser, Wm. H., Jr., U. S. Army
- Roberts, C. W., 26 Linden Ave., N. E., Atlanta
- Roberts, M. H., 33 Ponce de Leon Ave., N. E., Atlanta
- Rosenberg, H. J., 478 Peachtree St., N. E., Atlanta
- Rogers, J. Harry, 478 Peachtree St., N. E., Atlanta
- Rogers, Jas. T., U. S. Army
- Rouglin, L. C., 1st Natl. Bldg., Atlanta
- Rudder, Fred, The Gorgas Hospital, Ancon, Canal Zone
- Rushin, C. E., 478 Peachtree St., N. E., Atlanta
- Sage, D. Y., Medical Arts Bldg., Atlanta
- Sanders, A. S., 1660 N. Emory Road, N. E., Atlanta
- Sandison, J. Calvin, 478 Peachtree St., N. E., Atlanta
- Sauls, H. C., Medical Arts Bldg., Atlanta
- Savage, Jas. H., 645 Lee St., S. W., Atlanta (Deceased)
- Scarborough, J. E., Winship Clinic, Emory University
- Scheinbaum, C. N., Candler Bldg., Atlanta

Schenck, H. C., Georgia Department of Public Health, Atlanta
 Schneider, J. F., First National Bldg., Atlanta
 Sellers, T. F., Georgia Department of Public Health, Atlanta
 Selman, W. A., 157 Forrest Ave., N. E., Atlanta
 Shackelford, B. L., Medical Arts Bldg., Atlanta
 Shanks, Edgar D., 478 Peachtree St., N. E., Atlanta
 Shepard, V. Duncan, 33 Walker Ter., N. E., Atlanta
 Simmons, S. C., Jr., College Park
 Sims, Marshall R., 157 Forrest Ave., N. E., Atlanta
 Sinkoe, S. J., Candler Bldg., Atlanta
 Sloan, W. P., Candler Bldg., Atlanta
 Smith, Archibald, First National Bldg., Atlanta
 Smith, Carter, U. S. Army
 Smith, Chas. W., 770 Cypress St., N. E., Atlanta
 Smith, J. Gregg, Georgia Tech-Naval R. O. T. C., Atlanta (Asso.)
 Smith, Lewis M., U. S. Navy
 Smith, Linton M., 427½ Moreland Ave., N. E., Atlanta
 Smith, M. F., 918 Bankhead Highway, N. W., Atlanta
 Smith, W. A., Medical Arts Bldg., Atlanta
 Smith, W. Randolph, 478 Peachtree St., N. E., Atlanta
 Stampa, Samuel, Candler Bldg.,
 Staton, T. R., Station Hospital, Ft. Jackson, S. C.
 Stead, Eugene A., Jr., 50 Armstrong St., S. E., Atlanta
 Stewart, Calvin B., 478 Peachtree St., N. E., Atlanta
 Stone, Chas. F., Jr., Medical Arts Bldg., Atlanta
 Strickler, C. W., Jr., 123 Forrest Ave., N. E., Atlanta
 Strickler, C. W., 123 Forrest Ave., N. E., Atlanta
 Stubbs, Trawick H., Volunteer Bldg., Atlanta (Asso.)
 Swanson, Cosby, 478 Peachtree St., N. E., Atlanta
 Swanson, Homer S., Medical Arts Bldg., Atlanta
 Swint, R. C., 1811 N. Rock Springs Road, N. E., Atlanta (Deceased)
 Taranto, Morris B., Mortgage Guarantee Bldg., Atlanta
 Tarplee, Scott L., Grand Theater Bldg., Atlanta
 Thebaut, Ben Robert, Medical Arts Bldg., Atlanta
 Thomason, J. W., P. O. Box 204, East Point
 Thomason, W. L., 157 Forrest Ave., N. E., Atlanta
 Thompson, D. O., U. S. Army
 Thoroughman, Jas. C., U. S. Public Health Service, New Orleans, La.
 Thornton, Lawson, 478 Peachtree St., N. E., Atlanta
 Tidmore, T. L., 963 Plymouth Road, Atlanta
 Timberlake, G. B., B-66, Stevenson, Ala.
 Trimble, W. H., 478 Peachtree St., N. E., Atlanta
 Turk, L. N., Jr., Candler Bldg., Atlanta

Turner, John W., 151 Ponce de Leon Ave., N. E., Atlanta
 Upchurch, Wilborn E., U. S. Navy
 Upshaw, C. B., 18 Fourth St., N. E., Atlanta
 Van Buren, E., 768 Juniper St., N. E., Atlanta
 Van Dyke, A. H., Grant Bldg., Atlanta
 Varner, John B., Medical Arts Bldg., Atlanta (Asso.)
 Varner, Wm. D., 2788 Peachtree Road, N. E., Atlanta (Asso.)
 Vinson, C. D., 72 Anniston Ave., S. E., Atlanta
 Vinton, Luther M., 478 Peachtree St., N. E., Atlanta
 Visanska, Samuel A., 834 Briarcliff Road, N. E., Atlanta (Asso.)
 Vogt, Elkin, 478 Peachtree St., N. E., Atlanta
 Walker, Exum B., U. S. Navy
 Walker, John R., 922 W. Peachtree St., N. E., Atlanta
 Walton, John M., Georgia Department of Public Health, Atlanta
 Ward, Chas. S., 478 Peachtree St., N. E., Atlanta
 Warnock, C. Murray, 478 Peachtree St., N. E., Atlanta
 Warren, Wm. C., Jr., 478 Peachtree St., N. E., Atlanta
 Watson, Edwin R., P. A. Surg. (R) 4097, Marine Hospital, Galveston, Texas
 Waters, Wm. C., Jr., 762 Cypress St., N. E., Atlanta
 Weaver, J. C., 78 Ellis St., N. E., Atlanta (Hon.)
 Weinberg, Jas. I., 762 Cypress St., N. E., Atlanta
 Weinstein, A. A., U. S. Army
 Weitz, Frank, Medical Arts Bldg., Atlanta
 Wells, W. F., Medical Arts Bldg., Atlanta
 Weens, H. S., Grady Hospital, Atlanta
 West, C. M., Candler Bldg., Atlanta
 Whipple, Robert L., Jr., Medical Arts Bldg., Atlanta
 White, Cecil Glenn, Jr., U. S. Army
 White, James B., 1575 Rogers Ave., S. W., Atlanta
 White, James R., 478 Peachtree St., N. E., Atlanta
 Williams, Caroline Jane, 768 Juniper St., N. E., Atlanta
 Williams, George A., Medical Arts Bldg., Atlanta
 Willingham, T. I., 56 Fifth St., N. E., Atlanta
 Wilson, R. B., 478 Peachtree St., N. E., Atlanta
 Wolff, Bernard P., Medical Arts Bldg., Atlanta
 Wood, R. Hugh, Emory University Hospital, Atlanta
 Wright, E. S., U. S. Navy
 Yampolsky, Joseph, 478 Peachtree St., N. E., Atlanta
 York, Jesse H., Medical Arts Bldg., Atlanta
 Young, Clifton A., U. S. Naval Air Station, Atlanta (Asso.)
 Young, W. W., 478 Peachtree St., N. E., Atlanta (Deceased)

GLYNN COUNTY

Officers

President..... Willis, T. V.
 Vice-President..... Winchester, M. E.

Secretary-Treasurer Collier, Thos. W. Delegate..... Avera, J. B.
 Alternate Delegate Collier, Thos. W. Board of Censors: C. B. Greer, J. B. Avera and Thos. W. Collier

Members

Avera, J. B., Brunswick
 Burford, Robert S., Brunswick
 Coe, H. M., Brunswick
 Collier, Thos. W., Brunswick
 Conn, Webb, Brunswick
 Galin, A. N., U. S. Army
 Greer, C. B., Brunswick
 Harcock, Chas. R., Brunswick
 Harris, B. W., Brunswick
 Hicks, Jas. M., U. S. Army
 Johnson, Thos. H., Brunswick
 Lawson, W. G., U. S. Navy
 McDaniel, S. P., Brunswick
 Mitchell, L. C., Brunswick
 Newson, Erle T., St. Simons Island
 Simmons, James O., Woodbine
 Simmons, J. W., Brunswick
 Thomas, W. C., Brunswick
 Towson, Ira G., Sea Island
 Vermilye, John H., Lake City, Fla.
 Willis, Tom Vann, Brunswick
 Winchester, M. E., Brunswick

GORDON COUNTY

Officers

President..... Banks, G. T.
 Secretary-Treasurer..... Billings, J. E.
 Delegate..... Hall, W. D.
 Board of Censors..... Acree, M. A.

Members

Acree, M. A., Rt. 1, Calhoun
 Banks, Geo. T., Fair Mount
 Billings, J. E., Calhoun
 Hall, W. D., Calhoun
 Walter, R. D., U. S. Navy

GRADY COUNTY

Officers

President..... Reynolds, A. B.
 Secretary-Treasurer..... Rogers, J. V.

Members

Arline, T. J., Cairo (Hon.)
 Rehberg, A. W., Cairo
 Reynolds, A. B., Cairo
 Rogers, J. V., Cairo
 Walker, W. A., Cairo (Hon.)
 Warnell, J. B., Cairo

GREENE COUNTY

Members

President..... Ghesling, Goodwin
 Vice-President..... Lewis, W. Hill
 Secretary-Treasurer..... Killam, F. H.
 Delegate..... Richards, W. R.

Members

Ghesling, Goodwin, Greensboro
 Killam, F. H., Greensboro
 Lewis, W. H., Siloam
 Richards, W. R., Greensboro

GWINNETT COUNTY

Officers

President..... Hutchins, W. J.
 Vice-President..... Kelley, D. C.
 Secretary-Treasurer.....

Cain, Sylvester, Jr.

Delegate..... Puett, W. W.
 Alternate Delegate..... Chastain, J. R.

Members

Cain, Sylvester, Jr., Norcross
 Hinton, W. T., Dacula (Deceased)
 Hutchins, W. J., Buford
 Kelley, D. C., Lawrenceville
 Puett, W. W., Norcross

HABERSHAM COUNTY

Officers

President..... Jackson, J. B.
 Vice-President..... Swain, Bruce

Secretary-Treasurer.....Brabson, T. H.
 Delegate.....Garrison, D. H.
 Alternate Delegate.....Harden, O. N.

Members

Barrett, Clara, Georgia Department of
 Public Health, Atlanta
 Brabson, T. H., Cornelia
 Chandler, W. V., Baldwin (Hon.)
 Coffin, Betsy, Demorest
 Collins, Katherine R., Turnerville
 (Hon.)
 Crenshaw, Fred, Alto
 Crewse, Joe S., Alto
 Crow, H. E., Alto
 Garrison, D. H., Clarkesville
 Harden, O. N., Cornelia
 Hardman, C. T., Tallulah Falls
 Jackson, J. B., Clarkesville
 Nicholson, George T., Cornelia
 Swain, Bruce, Clarkesville
 Whelchel, F. C., Alto

HALL COUNTY**Officers**

President.....Meeks, Jesse L.
 Vice-President.....Harrison, W. B.
 Secretary-Treasurer.....Lancaster, H. H.
 Delegate.....Whelchel, C. D.
 Alternate Delegate.....Davis, B. B.

Members

Burns, J. K., Jr., Gainesville
 Butler, C. G., P. O. Box 13, Gaines-
 ville
 Chandler, B. B., Gainesville
 Cheek, Pratt, Gainesville
 Cheek, Pratt, Jr., U. S. Army
 Collins, Clyde, U. S. Army
 Davis, B. B., Gainesville
 Garner, W. R., Gainesville
 Gower, J. C., Gainesville
 Grove, E. W., U. S. Army
 Harrison, W. B., Gainesville
 Hill, H. W., U. S. Army
 Howard, Marcus L., U. S. Navy
 Joiner, Hartwell, Gainesville
 Lancaster, H. H., New Holland
 Loranger, James C., Claxton
 Meeks, Jesse L., Gainesville
 Neal, L. G., Cleveland
 Phillips, H. K., Helen
 Rogers, R. L., Gainesville
 Fitshaw, H. S., Gainesville
 Ward, Eugene L., Gainesville
 Whelchel, C. D., Gainesville

HANCOCK COUNTY**Officers**

President.....Darden, Horace
 Secretary-Treasurer.....Earl, H. L.
 Delegate.....Jernigan, C. S.

Members

Darden, Horace, Sparta
 Earl, H. L., Sparta
 Hutchings, E. H., Sparta
 Jernigan, C. S., Sparta
 Wiley, John W., Sparta

HARALSON COUNTY**Officers**

President.....King, O. D.
 Secretary-Treasurer.....Allen, C. H.

Members

Allen, C. H., Bremen
 Brock, W. B., Tallapoosa (Hon.)
 Eaves, B. F., Draketown (Hon.)
 Hutcheson, E. B., Buchanan (Hon.)
 King, O. D., Bremen
 Sanford, E. F., Buchanan (Deceased)

HART COUNTY**Officers**

President.....Meredith, A. O.
 Secretary-Treasurer.....Harper, G. T.

Members

Hanie, A. P., Hartwell
 Harper, G. T., Rt. 2, Dewy Rose
 Jenkins, J. I., Rt. 1, Hartwell
 Meredith, A. O., Hartwell
 Teasley, B. C., Hartwell

HENRY COUNTY**Officers**

President.....Carter, A. W., Jr.
 Vice-President.....Ellis, H. C.
 Secretary-Treasurer.....Colvin, E. G.

Members

Brandon, R. V., McDonough
 Carter, A. W., Jr., McDonough
 Colvin, E. G., Locust Grove
 Ellis, H. C., McDonough

HOUSTON-PEACH COUNTIES**Member**

Hendrick, A. G., Perry

JACKSON-BARROW COUNTIES**Officers**

President.....Harris, E. R.
 Vice-President.....Campbell, J. H.
 Secretary-Treasurer.....Rogers, A. A.

Members

Allen, L. C., Hoschton
 Allen, M. B., Hoschton
 Bowdoin, W. H., Statham
 Bryson, L. R., Hoschton (Hon.)
 Campbell, J. H., Commerce (Deceased)
 Harris, E. R., Winder
 Lord, C. B., Jefferson
 Mathews, W. L., Winder (Deceased)
 McDonald, E. M., Jefferson
 Pittman, O. C., U. S. Army
 Randolph, R. H., U. S. Navy
 Randolph, W. Quenton, Winder
 Randolph, W. T., Winder
 Rogers, A. A., Commerce
 Ross, S. T., Winder (Hon.)
 Russell, Alexander B., Winder
 Scroggins, P. T., Commerce
 Stinchcomb, R. P., Pendergrass (Hon.)
 Stovall, J. T., Jefferson

JASPER COUNTY**Officers**

President.....Pittard, L. Y.
 Secretary-Treasurer.....Lancaster, E. M.
 Delegate.....Belcher, F. S.
 Alternate Delegate.....Pittard, L. Y.

Members

Belcher, F. S., Monticello
 Lancaster, E. M., Shady Dale
 Pittard, L. Y., Monticello

JEFFERSON COUNTY**Officers**

President.....Revell, S. T. R.
 Secretary-Treasurer.....Lewis, John R.
 Delegate.....Revell, S. T. R.

Members

Bryant, V. L., Wadley
 Lewis, J. R., Louisville
 Revell, S. T. R., Louisville

JENKINS COUNTY**Officers**

President.....Lee, H. G.
 Vice-President.....Thompson, Cleveland
 Secretary-Treasurer.....Mulkey, Q. A.
 Delegate.....Lee, H. G.

Members

Barger, Thomas F., Perkins (Hon.)
 Lee, H. G., Millen
 Mulkey, A. P., Millen
 Mulkey, Q. A., Millen
 Rawls, Katherine, Sylvania
 Thompson, Cleveland, Millen

LAMAR COUNTY**Officers**

President.....Pritchett, D. W.
 Vice-President.....Jackson, J. H.

Secretary-Treasurer.....Traylor, S. B.
 Delegate.....Corry, J. A.

Members

Corry, J. A., Barnesville
 Jackson, J. H., Barnesville
 Pritchett, D. W., Barnesville
 Traylor, S. B., Barnesville

LAURENS COUNTY**Officers**

President.....Ferrell, R. G., Jr.
 Vice-President.....Coleman, A. T.
 Secretary-Treasurer.....Cheek, O. H.
 Delegate.....Cobb, T. R.
 Alternate Delegate.....Ferrell, R. G., Jr.
 Board of Censors: Wm. C. Thomp-
 son, C. A. Hodges, and A. T. Cole-
 man

Members

Barton, J. J., Dublin (Hon.)
 Bedingfield, R. A., Cadwell
 Bell, John A., Jr., U. S. Army
 Brantley, J. G., Wrightsville
 Bray, H. B., Wrightsville
 Carter, J. G., Scott
 Cheek, O. H., Dublin
 Claxton, E. B., Dublin
 Cobb, T. R., Dublin
 Coleman, A. T., Dublin
 Ferrell, R. G., Jr., Dublin
 Hicks, Chas. L., Dublin
 Hodges, C. A., Dublin
 Lanier, L. I., Soperton
 Moye, C. G., Brewton
 Thompson, W. C., Dublin
 Ware, A. D., Toombsboro

**SOUTH GEORGIA MEDICAL
 SOCIETY**

Berrien-Clinch-Cook-Echols-Lanier
 and Lowndes

Officers

President.....Williams, T. C.
 Vice-President.....Hutchinson, L. R.
 Secretary-Treasurer.....Farbar, M. E.
 Delegate.....Turner, W. W.
 Alternate Delegate.....Clements, H. W.

Members

Bird, Frank, Valdosta
 Burns, D. L., Valdosta
 Clements, H. W., Adel
 Crozier, G. T., Valdosta
 Farbar, M. E., G.S.C.W., Valdosta
 Giddens, C. C., Valdosta
 Hutchinson, L. R., Adel
 Johnson, A. M., Valdosta
 Little, A. G., Valdosta
 Mixson, J. F., Valdosta
 Oliphant, Jones B., Adel
 Owens, B. D., Valdosta (Asso.)
 Quarterman, P. C., Valdosta
 Quillian, E. P., Clyattville
 Saunders, Albert F., Valdosta
 Smith, E. J., Hahira
 Smith, J. R., Hahira
 Smith, Tom H., Valdosta
 Thomas, F. H., Valdosta
 Thomas, Jos. A., Valdosta
 Thompson, E. F., Valdosta
 Turner, W. W., Nashville
 Waugh, William, Nashville
 Williams, T. C., Valdosta

MACON COUNTY**Officer**

Secretary-Treasurer.....Adams, Thos. M.

Members

Adams, J. Fred, Montezuma
 Adams, Thos. M., Montezuma
 Derrick, H. C., Oglethorpe
 Savage, C. P., Montezuma
 Seay, E. Faxton, Marshallville

McDUFFIE COUNTY**Member**

Riley, B. F., Jr., Thomson

MERIWEATHER-HARRIS COUNTIES**Officers**

President.....Bennett, R. L.
 Vice-President.....Bennett, V. H.
 Secretary-Treasurer.....Gilbert, R. B.
 Delegate.....Irwin, Chas. E.
 Alternate Delegate.....Gilbert, R. B.

Members

Allen, W. P., Woodbury
 Bennett, Robert L., Warm Springs
 Bennett, V. H., Gay
 Ellis, W. P., Chipley
 Gilbert, R. B., Greenville
 Irwin, Chas. E., Warm Springs
 Jackson, T. W., Manchester
 Johnson, J. A., Manchester
 Kaplan, S. E., Greenville
 Kirkland, W. P., Manchester
 Raper, Hal Stuart, Warm Springs

MITCHELL COUNTY**Officers**

President.....Crovatt, J. G.
 Vice-President.....Burns, M. M.
 Secretary-Treasurer.....Belcher, D. P.
 Delegate.....Brim, J. C.
 Alternate Delegate.....Roles, C. L.

Members

Belcher, D. P., Pelham
 Brim, J. C., Pelham
 Burns, M. M., Pelham
 Crovatt, J. G., Camilla
 Reid, C. W., Pelham (Hon.)
 Roles, C. L., Camilla
 Stevenson, C. A., Camilla
 Ward, J. W., Baconton (Hon.)
 Williams, M. W., U. S. Army

MONROE COUNTY**Officers**

President.....Smith, W. J.
 Secretary-Treasurer.....Alexander, G. H.

Members

Alexander, G. H., Forsyth
 Goolsby, R. C., Sr., Forsyth (Hon.)
 Smith, B. L., Forsyth (Deceased)
 Smith, W. J., Forsyth
 Work, S. D., Jr., Forsyth

MONTGOMERY COUNTY**Officers**

Secretary-Treasurer.....Palmer, J. W.

Members

Hunt, J. E., Anniston Ordnance Depot, Anniston, Ala.
 Palmer, J. W., Ailey

MORGAN COUNTY**Officers**

President.....Fambrough, W. M.
 Secretary-Treasurer.....McGeary, W. C.
 Delegate.....Porter, J. L.
 Alternate Delegate.....McGeary, W. C.

Members

Dickens, C. H., Madison
 Fambrough, W. M., Bostwick
 McGeary, W. C., Madison
 Nicholson, J. H., Madison
 Porter, J. L., Rutledge

MUSCOGEE COUNTY**Officers**

President.....Threatte, Bruce
 Vice-President.....Gilliam, O. D.
 Secretary-Treasurer.....Lapides, Leon
 Board of Censors: John Mayher, Louie R. Edleson and O. D. Gilliam

Members

Beach, Bessie Mae, Columbus
 Bickerstaff, H. J., Swift Bldg., Columbus

Blanchard, Mercer, 204 Eleventh St., Columbus

Brannen, O. C., Murrah Bldg., Columbus

Brooks, H. W., Buena Vista

Bush, John, 313 14th St., Columbus

Carter, C. B., 1545 3rd Ave., Columbus (Hon.)

Cook, Wm. C., Swift-Kyle Bldg., Columbus

Cooke, W. L., Doctors Bldg., Columbus (Hon.)

Dillard, Guy J., Murrah Bldg., Columbus

Dykes, A. N., 1229 2nd Ave., Columbus

Edleson, Louis R., First National Bank Bldg., Columbus

Gaston, Joseph H., 1409 4th Ave., Columbus

Gilliam, O. D., Doctors Bldg., Columbus

Jenkins, W. F., City Hospital, Columbus

Jones, Wm. R., Doctors Bldg., Columbus

Jordan, W. P., Doctors Bldg., Columbus

Lapides, Leon, Swift Bldg., Columbus

Mayher, J. W., 1344 2nd Ave., Columbus

Mayher, W. E., 1344 2nd Ave., Columbus

McDuffie, J. H., Jr., 1120 3rd Ave., Columbus

Munn, E. K., Murrah Bldg., Columbus

Murray, G. S., Swift Bldg., Columbus

Peacock, C. A., Murrah Bldg., Columbus

Schley, Frank B., 303 11th St., Columbus

Spikes, J. L., Doctors Bldg., Columbus

Tatum, P. A., Columbus

Thompson, John B., Jr., Flowers Bldg., Columbus

Thrash, J. A., 1310 Broadway, Columbus

Threatte, Bruce, 204 11th St., Columbus

Tidwell, J. T., Columbus

Tillery, Bert, Swift-Kyle Bldg., Columbus

Venable, D. R., City Hospital, Columbus

Walker, John E., 1223 3rd Ave., Columbus

Willis, J. N., Swift Bldg., Columbus

Winn, John H., Swift Bldg., Columbus

Woodbridge, J. C., Murrah Bldg., Columbus

Yomans, J. R., 1600 Boulevard, Columbus

Young, S. E., Midland (Hon.)

NEWTON COUNTY**Officers**

President.....Travis, W. D.
 Secretary-Treasurer.....Mitchell, J. B.
 Delegate.....Travis, W. D.

Members

Huson, W. Joseph, Covington
 Mitchell, J. B., Porterdales
 Moore, Haywood L., 0-356441, M. C., 174th General Hospital, APO 562, c/o Postmaster, New York, New York
 Nesbit, F. C., Covington
 Pitts, Julius T., Newborn
 Sams, J. R., Covington
 Swan, W. K., Covington
 Travis, W. D., Covington

Waites, S. L., Covington
 Wilson, Pleas, Newborn

OCMULGEE COUNTY**Bleckley-Dodge-Pulaski Counties****Officers**

President.....Massey, W. F.
 Vice-President.....Coleman, Warren A.
 Secretary-Treasurer.....Batts, A. S.
 Delegate.....Batts, A. S.
 Alternate Delegate.....Fulghum, J. A.

Members

Batts, A. S., Hawkinsville
 Bush, Albert R., Hawkinsville
 Coleman, W. A., Eastman
 Evans, A. P., Hawkinsville
 Massey, W. F., Chester
 Mayo, J. Palmer, Eastman
 Parkerson, I. J., Eastman
 Smith, J. M., Cochran
 Whipple, R. L., Cochran

POLK COUNTY**Officers**

President.....Styles, O. R.
 Vice-President.....White, Geo. M.
 Secretary-Treasurer.....Ross, Grace R.
 Delegate.....Lucas, W. H.
 Alternate Delegate.....Whitely, Seals L.

Members

Chapman, W. A., Cedartown (Hon.)
 Chaudron, P. O., Cedartown
 Cooper, J. J., Cedartown
 Goldin, Robert B., Rockmart
 Good, John W., Cedartown
 Lucas, W. H., Cedartown
 McBryde, T. E., Rockmart
 Ross, Grace R., Cedartown
 Spanjer, Raymond F., Cedartown
 Styles, O. R., Cedartown
 White, Geo. M., Rockmart
 Whitely, S. L., Cedartown

RABUN COUNTY**Officers**

President.....Dover, J. C.
 Secretary-Treasurer.....Green, J. A.

Members

Dover, J. C., Clayton
 Green, J. A., Clayton

RANDOLPH-TERRELL COUNTIES

President.....Sims, A. R.
 Vice-President.....Arnold, J. T.
 Secretary-Treasurer.....Elliott, W. G.
 Delegate.....Massengale, L. R.
 Alternate Delegate.....Humber, J. W.
 Censors: J. C. Tidmore, F. S. Rogers and L. R. Massengale

Members

Arnold, J. T., Parrott
 Carter, George, Bluffton (Hon.)
 Crook, W. W., Cuthbert
 Elliott, W. G., Cuthbert
 Gary, Loren, Georgetown
 Harper, T. F., Coleman
 Humber, J. W., Lumpkin
 Kenyon, J. M., Richland (Hon.)
 Kenyon, Steve P., Dawson
 Lewis, J. H., Dawson (Hon.)
 Lunsford, J. F., Preston
 Martin, F. M., Shellman
 Martin, Robert B., III, U. S. Army
 Martin, Walter D., U. S. Army
 Massengale, Leonard R., Lumpkin
 Patterson, J. C., Cuthbert
 Rogers, F. S., Coleman
 Saurez, Annette McD., Cuthbert (Hon.)
 Sims, A. R., Richland
 Tidmore, Joseph C., Dawson

RICHMOND COUNTY

Officers

President.....Wright, Geo. W.
 Secretary-Treasurer.....Harrell, H. P.
 Delegate.....McGahee, R. C.
 Delegate.....Thomas, T. R., Jr.
 Alternate Delegate.....Agee, M. P.
 Alternate Delegate.....Chaney, R. H.

Members

Agee, M. P., 753 Broad St., Augusta
 Allen, Lane H., Medical College,
 Augusta
 Battey, Colden R., 638 Greene St.,
 Augusta
 Battey, W. W., Jr., 561 Telfair St.,
 Augusta
 Beard, B. C., University Hospital,
 Augusta
 Beddingfield, W. R., S. F. Bldg.,
 Augusta
 Bernard, G. T., 204 13th St., Augusta
 Bowen, J. B., University Hospital,
 Augusta
 Briggs, A. P., University Hospital,
 Augusta
 Brittingham, John W., 1345 Greene
 St., Augusta
 Brown, T. P., Marion Bldg., Augusta
 Bryans, C. L., 967 Meigs St., Augusta
 Burdshaw, J. F., Johnson Bldg.,
 Augusta
 Burdshaw, Wm. J., 718 Monte Sano
 Ave., Augusta
 Butler, J. H., S. F. Bldg., Augusta
 Chaney, R. H., 1001 Greene St.,
 Augusta
 Cleckley, Hervey M., University Hos-
 pital, Augusta
 Coleman, Warren, 2749 Hillcrest,
 Augusta (Hon.)
 Corbitt, Melvis O., 1039 Holden St.,
 Augusta
 Cranston, W. J., 1345 Greene St.,
 Augusta
 Davis, Abe J., 503 Greene St.,
 Augusta
 DeVaughn, N. M., Marion Bldg.,
 Augusta
 Goodrich, W. H., S. F. Bldg., Augusta
 Gray, J. D., 1345 Greene St., Augusta
 Harper, Harry T., Jr., S. F. Bldg.,
 Augusta
 Harrell, H. P., S. F. Bldg., Augusta
 Hensley, E. A., Gibson
 Hock, Chas. W., University Hospital,
 Augusta
 Holmes, L. P., S. F. Bldg., Augusta
 Jenkins, H. B., ASF Regional Hos-
 pital, Camp Stewart
 Jennings, W. D., Herald Bldg.,
 Augusta
 Johnson, Robert W., 1345 Greene St.,
 Augusta
 Jones, G. Frank, Jr., University Hos-
 pital, Augusta
 Kelly, G. Lombard, University of Ga.
 School of Medicine, Augusta
 Kennedy, F. A., 1345 Greene St.,
 Augusta
 Kilpatrick, A. J., 407 7th St., Augusta
 Lee, F. Lansing, S. F. Bldg., Augusta
 Leonard, Robert E., 1001 Greene St.,
 Augusta
 Levy, M. S., S. F. Bldg., Augusta
 Lewis, S. J., S. F. Bldg., Augusta
 Major, Robert C., Medical College,
 Augusta
 Mathews, Marion, University Hospital,
 Augusta
 Mathews, W. E., S. F., Bldg., Augusta

May, E. R., Lincolnton
 McGahee, R. C., 1345 Greene St.,
 Augusta
 Mealing, Henry G., S. F. Bldg.,
 Augusta
 Mettler, F. A., Columbia University
 College of Physicians and Surgeons,
 New York City
 Michel, H. M., University Hospital,
 Augusta
 Miller, Abraham, 1345 Greene St.,
 Augusta
 Miller, Harold A., Box 359, Augusta
 Milligan, K. W., 942 Greene St.,
 Augusta
 Mountain, G. W., 1121 Monk Sound
 Ave., Augusta
 Mulherin, F. X., 1001 Greene St.,
 Augusta
 Mulherin, Philip A., University Hos-
 pital, Augusta
 Mulherin, W. A., 1211 Greene St.,
 Augusta (Deceased)
 Murphey, E. E., 432 Telfair St.,
 Augusta
 Norvell, J. T., 1246 Greene St.,
 Augusta
 Persall, John T., Jr., S. F. Bldg.,
 Augusta
 Phinizy, Thomas, 1345 Greene St.,
 Augusta
 Price, W. T., Leonard Bldg., Augusta
 Pund, Edgar R., Medical College,
 Augusta
 Rhodes, R. L., S. F. Bldg., Augusta
 Rinker, J. Robert, University Hospital,
 Augusta
 Risteen, W. A., University Hospital,
 Augusta
 Roberts, W. H., 828 Greene St.,
 Augusta
 Roule, J. Victor, S. F. Bldg., Augusta
 Sanderson, E. S., Medical College,
 Augusta
 Scharnitzky, E. O., 1262 Greene St.,
 Augusta
 Silver, D. M., S. F. Bldg., Augusta
 Templeton, C. M., S. F. Bldg., Augusta
 Tessier, Claude E., Masonic Bldg.,
 Augusta
 Thomas, D. R., S. F. Bldg., Augusta
 Thurmond, J. W., 407 7th St., Augusta
 Timmons, C. C., 401 Milledge Road,
 Augusta
 Todd, L. N., University Hospital,
 Augusta
 Torpin, Richard, University Hospital,
 Augusta
 Volpitto, P. P., University Hospital,
 Augusta
 Ward, C. D., 1345 Greene St., Augusta
 Weeks, J. L., Harlem (Hon.)
 Weeks, R. B., S. F. Bldg., Augusta
 Williams, W. J., S. F. Bldg., Augusta
 Willis, C. H., S. F. Bldg., Augusta
 Winters, A. C., Veterans Hospital,
 Salt Lake City, Utah (Asso.)
 Witten, H. O., Veterans Hospital,
 Augusta
 Woodbury, Robert A., Medical College,
 Augusta
 Wright, Geo. W., 1345 Greene St.,
 Augusta
 Wright, P. B., 1345 Greene St.,
 Augusta

ROCKDALE COUNTY

Officer

Secretary-Treasurer.....Griggs, H. E.
 Members
 Brown, P. J., Conyers
 Griggs, H. E., Conyers

SCREVEN COUNTY

Member

Bennett, W. H., Sylvania

SPALDING COUNTY

Officers

President.....Miles, W. C.
 Vice-President.....Hawkins, T. I.
 Secretary-Treasurer.....Vinson, T. O.
 Delegate.....Walker, Geo. L.
 Alternate Delegate.....Vinson, T. O.

Members

Cagle, W. D., Griffin
 Copeland, H. J., Griffin
 Copeland, H. W., Griffin
 English, R. E. L., Griffin
 Floyd, T. J., Jr., Griffin
 Forrer, D. A., Griffin
 Frye, A. H., Griffin
 Grubbs, J. H., Molena
 Hammond, Robert L., Jackson
 Hawkins, T. I., Griffin
 Head, D. L., Zebulon
 Head, M. M., Zebulon
 Howard, I. B., Williamson
 Huckaby, A. H., Griffin
 Hunt, K. S., Griffin
 Miles, W. C., Griffin
 Smaha, T. G., Griffin
 Perkins, H. R., Griffin
 Stuckey, Ann, Griffin
 Vinson, T. O., Griffin
 Walker, Geo. L., Griffin

STEPHENS COUNTY

Officers

President.....Isbell, J. E. D.
 Vice-President.....Sapp, C. J.
 Secretary-Treasurer.....Ayers, C. L.
 Delegate.....Sapp, C. J.
 Alternate Delegate.....Terrell, J. H.
 Board of Censors: W. B. Heller and
 N. A. Bryan

Members

Ayers, C. L., Toccoa
 Ayers, S. E., U. S. Navy
 Bryan, N. A., China
 Chaffin, E. F., Toccoa
 Edge, J. H., Toccoa (Hon.)
 Good, W. H., Jr., Toccoa
 Heller, W. B., Toccoa
 Isbell, J. E. D., Toccoa
 Sapp, C. J., Toccoa
 Schaefer, W. B., U. S. Army
 Swain, W. H., Martin (Deceased)
 Terrell, J. H., Toccoa
 Welton, Felix B., 7 N. Thompson
 St., Whiteville, N. C.

SUMTER COUNTY

Officers

President.....Boyette, L. S.
 Vice-President.....Primrose, A. C.
 Secretary-Treasurer.....Enzor, R. H.
 Delegate.....Wise, B. T.
 Alternate Delegate.....Primrose, A. C.

Members

Boyette, L. S., Ellaville
 Enzor, R. H., Smithville
 Gatewood, T. Schley, Americus
 Logan, J. C., Plains
 Primrose, A. C., Americus
 Smith, Herschel A., Americus
 Wise, B. J., Americus
 Wise, B. T., Americus
 Wood, Kenneth, Leslie

TATTNALL COUNTY

Officers

President.....Collins, J. C.
 Vice-President.....Tootle, G. W.
 Secretary-Treasurer.....Hughes, J. M.
 Delegate.....Strickland, L. V.
 Alternate Delegate.....Hughes, J. M.

Officers

Collins, J. C., Collins
 Colson, A. C., Glennville
 Hughes, J. M., Glennville
 Jelks, L. R., Reidsville
 Strickland, L. V., Cobbtown
 Tootle, G. W., Glennville

TAYLOR COUNTY**Officers**

President.....Beason, Lewis
 Vice-President.....Bryan, S. H.
 Secretary-Treasurer,

Montgomery, R. C.
 Delegate.....Montgomery, R. C.

Members

Beason, Lewis, Butler
 Eryan, S. H., Reynolds
 Montgomery, R. C., Butler
 Sams, F. H., U. S. Army

TELFAIR COUNTY**Officers**

President.....Born, W. H.
 Vice-President.....Maloy, C. J.
 Secretary-Treasurer.....Mann, Frank R.
 Delegate.....Parkerson, S. T.
 Board of Censors: W. H. Born, S. T.
 Parkerson and C. J. Maloy

Members

Born, W. H., McRae
 Kusnitz, Morris, Jr., Alamo
 Maloy, C. J., McRae
 Mann, Frank R., McRae
 Parkerson, S. T., McRae

THOMAS COUNTY**Officers**

President.....Collins, J. J.
 Vice-President.....Ainsworth, Harry
 Secretary-Treasurer,

Erickson, Mary J.

Members

Ainsworth, Harry, Thomasville
 (Deceased)
 Bell, R. F., Thomasville
 Bellhouse, Helen W., Thomasville
 Bugg, Everett I., Jr., Thomasville
 Collins, J. J., Thomasville
 Daniel, Frank C., Pavo
 Erickson, Mary J., Thomasville
 Ferguson, C. H., Thomasville
 Garrett, J. A., Meigs
 Harner, Jos. W., Jr., Thomasville
 Isler, J. N., Meigs
 Jarrell, W. W., Thomasville
 King, J. T., Thomasville
 Little, A. D., Thomasville
 Lundy, L. L., Boston
 Mobley, J. W., Jr., Thomasville
 Moore, H. M., Thomasville
 Mosteller, Ralph, Thomasville
 Readling, Herbert F., Thomasville
 Reid, Jas. W., Thomasville
 Sanchez, S. E., Barwick
 Wahl, E. F., Thomasville
 Wall, C. K., Thomasville
 Watt, C. H., Thomasville

TIFT COUNTY**Officers**

President.....Harrell, D. B.
 Vice-President.....Hendricks, W. H.
 Secretary-Treasurer.....Pittman, C. S.
 Delegate.....Hendricks, W. H.
 Alternate Delegate.....Pittman, C. S.

Members

Andrews, Agnew, Tifton
 Andrews, Ella F., Tifton
 Evans, E. L., Tifton
 Fleming, C. A., Tifton
 Harrell, D. B., Tifton
 Hendricks, W. H., Tifton

Jones, R. E., U. S. Army
 LeRoy, Albert G., Tifton
 Little, Tom F., U. S. Army
 Pickett, F. B., Ty Ty
 Pittman, Carl S., Tifton
 Pittman, C. S., Jr., U. S. Army
 Shaw, M. F., Omega
 Smith, W. T., Tifton (Deceased)
 Webb, M. L., Tifton
 Zimmerman, Charles E., Tifton
 Zimmerman, W. F., U. S. Army

TOOMBS COUNTY**Officer**

Secretary-Treasurer.....Aiken, W. W.

Members

Aiken, W. W., Lyons
 Darby, V. L., Vidalia
 Findley, C. W., Vidalia
 Goss, O. S., Vidalia
 Mercer, J. E., Vidalia
 Williams, Chas. D., Vidalia
 Youmans, H. D., Lyons

TRI COUNTY**Calhoun-Early-Miller Counties****Officers**

President.....Holland, S. P.
 Vice-President.....Sharp, C. K.
 Secretary-Treasurer.....Standifer, J. G.

Members

Barksdale, C. R., Blakely
 Baughn, E. B., Colquitt
 Beard, J. S., Edison
 Bridges, R. R., Leary
 Hattaway, J. C., Edison
 Hays, W. C., Colquitt
 Holland, S. P., Blakely
 Houston, W. H., Colquitt
 Sharp, C. K., Arlington
 Shepard, W. O., Bluffton
 Standifer, J. G., Blakely
 Twitty, C. W., Newton
 Wall, W. H., Blakely

TRI-COUNTY**Liberty-Long-McIntosh Counties****Officer**

Secretary-Treasurer.....Middleton, O. D.

Members

Armistead, I. G., Townsend
 Middleton, O. D., Ludowici
 Ogden, I. K., Darien

TROUP COUNTY**Officers**

President.....Harvey, C. W.
 Vice-President.....Amis, F. J.
 Secretary-Treasurer.....Arnold, E. T., Jr.
 Delegate.....Whitehead, C. M.
 Alternate Delegate.....Freeman, T. N.

Members

Amis, F. J., Hogansville
 Arnold, E. T., Jr., Hogansville
 Auten, W. J., LaGrange
 Avery, R. M., LaGrange
 Callaway, Enoch, LaGrange
 Chambers, James W., LaGrange
 Clark, W. H., LaGrange
 Freeman, Thos. N., LaGrange
 Grace, Kenneth D., U. S. Army
 Hadaway, W. H., LaGrange
 Hammett, H. H., LaGrange
 Harvey, C. W., Hogansville
 Herman, E. C., U. S. Navy
 Holder, J. S., U. S. Army
 Jones, H. T., West Point
 Lane, J. E., LaGrange
 Lee, R. O., LaGrange
 McCall, W. R., LaGrange
 McCulloh, Hugh, Jr., West Point
 Morgan, D. E., LaGrange
 Morgan, J. C., West Point

O'Neal, R. S., LaGrange
 Park, E. R., LaGrange
 Phillips, W. P., LaGrange
 Ridley, F. M., LaGrange
 Rogers, Jos. H., U. S. Army
 Rutland, S. C., LaGrange
 Smith, M. E., U. S. Army
 Taylor, John L., LaGrange
 Whitehead, C. Mark, LaGrange
 Williams, C. O., West Point

TURNER COUNTY**Officers**

President.....Turner, W. J.
 Secretary-Treasurer.....Baxter, J. H.

Members

Baxter, J. H., Ashburn
 Stephens, L. D., Sycamore (Deceased)
 Story, W. L., Ashburn
 Turner, W. J., Ashburn

UPSON COUNTY**Officers**

President.....Kellum, J. M.
 Vice-President.....Woodall, James A.
 Secretary-Treasurer,

Blackburn, John D.

Delegate.....Bridges, B. L.
 Alternate Delegate.....Garner, J. E.

Members

Adams, B. C., Thomaston
 Blackburn, John D., Thomaston
 Bridges, B. L., Thomaston
 Carter, R. L., Thomaston
 Garner, J. E., Thomaston
 Harris, C. A., The Rock
 Kellum, J. M., Americus
 McKenzie, J. M., Thomaston
 Woodall, James A., Thomaston

**WALKER-CATOOSA-DADE
COUNTIES**

President.....Hammond, D. W.
 Vice-President.....Simonton, F. H.
 Secretary-Treasurer.....O'Connor, F. L.
 Delegate.....Simonton, F. H.
 Alternate Delegate.....Alsobrook, J. S.
 Board of Censors: D. W. Hammond,
 F. L. O'Connor and S. B. Kitchen

Members

Alsobrook, J. S., Rossville (Hon.)
 Coulter, R. M., LaFayette (Hon.)
 Elder, D. G., Chickamauga
 Gardner, J. L., Sulphur Springs
 Hammond, D. W., LaFayette
 Kitchens, S. B., LaFayette
 Middleton, D. S., Rising Fawn (Hon.)
 O'Connor, F. L., Rossville
 Shepard, R. C., LaFayette
 Shields, H. F., Chickamauga
 Simonton, Fred H., Chickamauga
 Stephenson, Chas. W., Ringgold
 Vasey, G. C., U. S. Army

WALTON COUNTY**Officer**

Secretary-Treasurer.....Floyd, Chas. F.

Members

Anderson, M. W., Social Circle
 Floyd, Chas. F., Loganville
 Gardine, John, Jersey
 Miller, H. A., 134 Homewood Drive,
 Fairmont, Minn. -
 Pirkle, J. A., Monroe

WARE COUNTY**Officers**

President.....Stoner, W. P.
 Vice-President.....Gay, J. R.
 Secretary-Treasurer,

McCullough, Kenneth

Delegate.....Reavis, W. F.

Members

Atwood, Geo. E., Waycross
 Bradley, D. M., Waycross

Bruce, F. M., Homerville
 Bussell, B. R., Waycross
 Carswell, H. J., Waycross
 DeLoach, A. W., Waycross
 Denny, R. L., Alma
 Elder, E. B., Flagler Hospital, St. Augustine, Fla.
 Flanagan, W. M., Waycross
 Fleming, A., Folkston
 Gay, Joseph R., Waycross
 Goldman, Benj., Hazlehurst
 Goldwasser, Fred I., Alma
 Hafford, W. C., Waycross
 Hawkins, L. M., Blackshear
 Hendry, G. T., Blackshear
 Hendry, Katherine M., 24 Mildred Ave., Asheville, N. C.
 Huey, H. G., Homerville (Deceased)
 McCollum, R. Roy, Jr., Kingsland
 McCoy, W. R., Folkston
 McCullough, Kenneth, Waycross
 Minchew, B. H., Waycross
 Oden, T. E., Blackshear
 Perland, J. E., Waycross
 Reavis, W. F., Waycross
 Schanze, Raymond A., Homerville
 Schneider, W. J., Folkston
 Sharpe, W. W., III, Alma
 Stillwell, J. D., Waycross
 Stoner, W. P., Waycross
 Witmer, C. A., Waycross
 Youmans, C. R., Hazlehurst

WARREN COUNTY**Officers**

President..... Cason, H. B.
 Vice-President..... Ware, F. L.
 Secretary-Treasurer..... Davis, A. W.
 Delegate..... Cason, H. B.
 Alternate Delegate..... Davis, A. W.

Members

Cason, H. B., Warrenton
 Davis, A. W., Warrenton
 Kennedy, H. T., U. S. Navy
 Ware, F. L., Warrenton

WASHINGTON COUNTY**Officer**

Secretary-Treasurer..... Rawlings, F. B.

Members

Burdett, J. R., Tennille (Hon.)

Dillard, J. B., Davisboro (Hon.)
 Helton, B. L., Sandersville
 King, W. R., Tennille
 Leonard, O. D., Tennille
 Newsom, N. J., Sandersville
 Newsome, Emory G., Sandersville
 Overby, N., Sandersville
 Rawlings, F. B., Sandersville
 Rawlings, William, Sandersville
 Rogers, O. L., Sandersville
 Taylor, Ralph L., Davisboro
 Vickers, T. E., Harrison (Hon.)

WAYNE COUNTY**Officers**

President..... Tyre, J. Lawton
 Vice-President..... Ritch, Thos. G.
 Secretary-Treasurer..... Ritch, Una F.
 Delegate..... Colvin, J. T.
 Alternate Delegate..... Leaphart, J. A.

Members

Colvin, J. T., Jesup
 Harper, F. M., U. S. Navy
 Leaphart, J. A., Jesup
 Murphy, F. E., Jr., U. S. Army
 Phillips, C. M., Jr., U. S. Marines
 Ritch, Thos. G., Jesup
 Ritch, Una F., Jesup
 Tyre, J. Lawton, Screven
 Yoemans, Neal F., U. S. Navy
 Yoemans, Woodrow, U. S. Army

WHITFIELD COUNTY**Officers**

President..... Engelking, Chas. F.
 Vice-President..... Whitley, James R.
 Secretary-Treasurer..... Ault, H. J.
 Delegate..... Starr, Trammell
 Board of Censors: James R. Whitley,
 G. L. Broadrick and H. L. Erwin

Members

Ault, H. J., Dalton
 Bradford, J. E., Spring Place
 Bradley, R. H., Chatsworth
 Broadrick, G. L., Chattanooga, Tenn.
 Brown, W. E., Dalton
 Colvard, T. W., Crandall (Deceased)
 Dickie, E. H., Chatsworth
 Engelking, Chas. F., Dalton
 Erwin, H. L., Dalton
 Kerr, George S., Dalton
 Little, G. H., U. S. Army

McAfee, J. G., Dalton (Hon.)
 Ragland, Fred B., U. S. Army
 Rollins, J. C., Dalton
 Rosen, E. A., U. S. Army
 Sams, Henry L., Dalton
 Shellhorse, E. O., Dalton (Deceased)
 Starr, Trammell, Dalton
 Steed, J. H., Dalton
 Temples, Leo G., U. S. Army
 Whitley, James R., Dalton
 Wood, D. Lloyd, U. S. Army

WILCOX COUNTY**Officers**

President..... Harris, V. L.
 Secretary-Treasurer..... Ellis, S. B.

Members

Bussell, B. R., Rochelle (Hon.)
 Dorsey, H. A., Pitts (Hon.)
 Ellis, S. B., Pitts
 Harris, V. L., Rochelle

WILKES COUNTY**Officers**

President..... Simpson, A. W.
 Vice-President..... Nash, T. C.
 Secretary-Treasurer..... Stephens, R. G.
 Delegate..... Cheves, H. L.
 Alternate Delegate..... Harriss, H. T.

Members

Casteel, L. R., Washington
 Cheves, H. L., Union Point
 Gibson, F. N., Thomson
 Harriss, H. T., Washington
 Nash, T. C., Philomath
 Simpson, A. W., Washington
 Simpson, A. W., Jr., Washington
 Smith, R. H., Lincolnton
 Stephens, R. G., Washington
 Wills, C. E., Washington
 Wood, O. S., Washington

WORTH COUNTY**Officer**

Secretary-Treasurer..... Sumner, G. S.

Members

Bell, P. E., Sylvester (Hon.)
 Harris, E. C., Sylvester
 Jefford, T. C., Sylvester (Hon.)
 Sessions, W. W., Sumner (Deceased)
 Sumner, G. S., Sylvester
 Tipton, W. C., Sylvester (Deceased)
 Tracy, J. L., Jr., Sylvester

MANUFACTURERS' HEALTH CLINIC

(Continued from page 252)

equipped first-aid rooms, the average size of which is eight by twelve feet. In each are walls painted white, lavatory, first-aid wall cabinets, treatment tables, cots, stretchers, the necessary number of chairs, paper towels, cups, waste paper baskets, and floor linoleum. The remaining two plants have first-aid kits.

The Industrial Hygiene Service has assisted in promoting the project, in the survey of the environment of each plant from a sanitary and health standpoint, in the development of records, in the outlining of the nurse's duties, and in the arrangements for chest x-ray examinations, on a survey basis, of all employees. The 35 mm. photofluorographic portable unit of the Tuberculosis Control Division of the State Department of Health is utilized in these surveys, the first of which was conducted in September 1943.

Benefits from the Manufacturers' Clinic have been equally great for both owner and employee; greater production at less cost on the one hand

and less suffering and improved morale on the other.

L. M. PETRIE, M. D., *Director*,
 Industrial Hygiene Service,
 Division Preventable Diseases.

UNRRA MAKES PROGRESS

A shipment of 900 tons of desperately needed medical supplies sent by UNRRA has arrived in Rome for distribution through Italian government authorities, and more are on the way, according to word received from Richard K. Myers, Assistant Chief of UNRRA's Medical and Sanitation Supplies Division.

Mr. Myers is in Rome to aid in supervising the distribution. The shipment was made up of 23,000 separate cases of the vital medicines and equipment. Already 2,800 cases have been shipped to provinces most in need of them including Sicily, Lucania, Campania, Abruzzi, and Lazio and they are being distributed to hospitals and health centers for immediate use. UNRRA already has provided 100 ambulances in Italy which it obtained from military surpluses in Europe.

The Journal *of the* Medical Association of Georgia

INDEX

Volume XXXIV

January-December, 1945

PUBLICATION COMMITTEE

Cleveland Thompson, M.D.
Edgar D. Shanks, M.D.

EDITOR

Edgar D. Shanks, M.D.

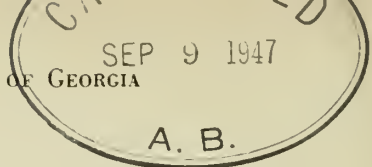
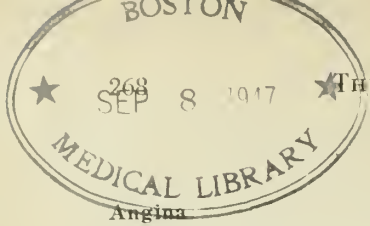
ASSOCIATE EDITORS

T. C. Davison, M.D.
Daniel C. Elkin, M.D.
Jack C. Norris, M.D.
Carter Smith, M.D.
C. B. Upshaw, M.D.

EXECUTIVE SECRETARY

Viola Berry

31742



INDEX OF SUBJECTS

A. B.

A

Angina
Angina Pectoris. October 1945. Jeff L. Richardson, Atlanta 195

Arterial Thromboses
Multiple Arterial Thromboses Involving the Major Vessels of the Lower Extremities and the Right Arm. February 1945. Arthur D. Little, Thomasville, and George T. McCutchen, M.C., Army of the United States 34

B

Babies
Georgia's "GI" Babies. March 1945. Edwin R. Watson, Atlanta 64

C

Cancer
Clinical Aspects and Treatment of Cutaneous Cancer. February 1945. Wm. L. Dobes, Atlanta, and Philip H. Nippert, M.C.-V (S) USNR 25
Treatment of Cancer of the Breast. January 1945. J. L. Campbell, Atlanta 1

D

Directory for 1945 254
Dougherty County
Why Are You A Citizen of Dougherty County? January 1945. J. M. Barnett, Albany 10

E

Editorials
Annual Session of the Association 225
Annual Session of the Association Cancelled 39
Births and Deaths 1944 38
Chronic Anxiety 250
1945 Christmas Gift: The United Nations Organization 249
Clinical Pulmonary Tuberculosis 14
Constructive Program for Medical Care 182
Cooperative Effort Is Needed 138
Current Medical Legislation 97
Deferment of Premedical and Predental Students 79
Dog Days 179
Don't Let George Do It 205
Don't Neglect Cancer 38
Economic Issues Facing Hospitals Theme of Second Hospital Review 226
Educational Opportunities for Army Doctors 100
Fifty Years of X-Rays 204
General Bayne-Jones Emphasizes Importance of Research on National Scale 139
In Defense of Georgia's State Board of Health 58
Longevity of the American People in 1943 118
Many Limb Infections Cured with Penicillin Injections 161
Medical Supplies: Their Transportation 78
Meet Mr. Dingell 39

National Hospital Day 1945 Finds "Hospitals Fight on Two Fronts" 120
No State Convention This Year 57
Organized Medicine's Plan 37
Penicillin and Sulfadiazine Very Effective in Pneumonia 181
"Perhaps the Word 'Reciprocity' Will Do" 137
Physical Medicine 205
Physically Handicapped Worker Efficient When Given Job For Which He Is Suited 78
Poliomyelitis 139
Says Courts Need Medical Guidance in Handling Crime Among the Aged 58
Shall Penicillin Become Proprietary? 139
The Challenge of the Field Army of the American Cancer Society 77
The Georgia Cancer Control Program 160
The Invisible Ray 251
The Supply of Physicians 180
The Year 1945. Will It Be More Blood, Sweat and Tears? 15
Tularemia: A Warning 251
Twixt Us Doctors 13
United National Clothing Collection 59
V-E Day Means Bigger Task for Army Medical Department 120
War Ends With Many Problems Still Facing American Medicine 180
What Will Mr. Truman Do About Medicine? 98
William A. Mulherin, M.D. 117
Work of Medical Department in World War II 227

Education
University of Georgia School of Medicine Plans Large Medical Center. August 1945. G. Lombard Kelly, Augusta 159

Elkin
William Simpson Elkin. May 1945. Wm. S. Goldsmith, Stone Mountain 95

Epidemics
Food-Borne Epidemics. April 1945. L. M. Petrie, Atlanta 82

G

Glaucoma
Glaucoma: Its Diagnosis and Management. July 1945. William O. Martin, Jr., Atlanta 135

H

Heart
Coronary Heart Disease: Diagnosis and Treatment. November 1945. John W. Brittingham, Augusta 219
Heart-Vascular Aging. April 1945. Edwin S. Byrd, Atlanta 74

I
Index Volume XXXIV 267
Index of Subjects 268
Index of Authors 270

Infant Feeding Problems

- Two Common Infant Feeding Problems.
February 1945. Paul R. Ensign, Atlanta 40

Intravenous Fluids

- The Choice and Proper Use of Intravenous
Fluids. March 1945. Thomas Harrold,
Macon 47

K**Kidney**

- Fused Kidney, Having Supernumerary
Ureter With Extravesical Orifice; Treat-
ed by Heminephrectomy of the Left Half.
November 1945. J. Robert Rinker, Au-
gusta 225

M**Measles**

- Serum Globulin for Measles Immunization.
June 1945. Guy G. Lunsford, Atlanta 123

Medical Needs

- Concerning Georgia's Medical Needs: A
Few Facts, Fallacies and Figures. De-
cember 1945. C. W. Roberts, Atlanta 239

Medicine

- American Medicine Tomorrow. March 1945.
Mac F. Cahal, Chicago 53
The Evolution of Medicine. July 1945.
Cleveland Thompson, Millen 127

Morphine Addiction

- Treatment of Morphine Addiction. August
1945. Joseph C. Massee, Atlanta 154

Myoma

- Ruptured Uterine Myoma Simulating Rup-
tured Tubal Pregnancy With Hemor-
rhage. May 1945. James W. Pilcher, Den-
nis M. Cornett and Grady N. Coker, Can-
ton 94

N**Nephrotic Edema**

- Acacia Treatment of Nephrotic Edema.
March 1945. L. L. Whitley, Athens 51

O**Obstetrics**

- Diagnosis and Therapeutic Uses of Pitu-
itary Extracts in Obstetrics. June 1945.
R. A. Bartholomew, Atlanta 110

P**Pain**

- Pain in the Chest: Its Significance. No-
vember 1945. C. C. Aven, Atlanta 221
Relief From Pain. July 1945. W. A. Ris-
teen, Augusta 132

Patient

- I Became A Patient. April 1945. T. C.
Davison, Atlanta 72

Peptic Ulcer

- The Surgery of Peptic Ulcer. December
1945. John W. Turner, Atlanta 243

Peripheral Arterial Disease

- Physical Therapy at Home For Peripheral
Arterial Disease. May 1945. Christopher
J. McLoughlin, Atlanta 91

R**Renal Cysts**

- Multiple and Solitary Renal Cysts. Sep-
tember 1945. Samuel J. Sinkoe, Atlanta 171

Rheumatic Fever

- The Use of the Antistreptolysin Titer in
the Differential Diagnosis of Rheumatic
Fever and Allied Conditions. January
1945. Harry Parks, M.C., A.U.S., Fort
Benning 5

Rheumatic Heart Disease

- Problems in the Treatment of Rheumatic
Heart Disease. November 1945. Joseph
Yampolsky, Atlanta 213

Respiratory Diseases of Infants and Children

- Recent Advances in the Treatment of Res-
piratory Diseases of Infants and Chil-
dren. October 1945. Wm. Willis Ander-
son, Atlanta 198

S**Sarcoidosis**

- Sarcoidosis. May 1945. Carter Smith, M.C.,
Army of the United States and H. Cliff
Sauls, Atlanta 87

Sciatic Pain

- Neurosurgical Aspects of Lumbar and Sci-
atic Pain. August 1945. Edgar F. Fin-
cher, Atlanta 150

Stomach

- Leather-Bottle Stomach. June 1945. Frank
K. Boland, Atlanta 107

Stones

- Common Duct Stones. February 1945. Ben
H. Clifton, Atlanta 30

Syphilis

- Biologic False Positive Serologic Tests for
Syphilis. August 1945. Albert Heyman,
Atlanta 165
Early Congenital Syphilis. October 1945.
Edwin R. Watson, Macon 200
False Positive Reactions in the Serodiag-
nostic Tests for Syphilis. September
1945. E. L. Webb, Atlanta 184
Relapsing Syphilis After Inadequate Pen-
icillin Therapy. June 1945. Hugh Hailey,
Atlanta 116

T**Tuberculosis**

- Tuberculosis: Whose The Burden? June
1945. H. C. Schenck, Atlanta 113

Typhus

- Expanded Typhus Control Program. No-
vember 1945. Roy J. Boston, Atlanta 231

V**Varicose Veins**

- Combined Surgical and Injection Treatment
of Varicose Veins. April 1945. Chas. E.
Rushin, Atlanta 67

Venereal Disease

- The Georgia Rapid Treatment Centers for
Venereal Diseases. January 1945. John
M. Walton, Atlanta 16

W

World War II

- How Good Is Navy Medical Care In World War II? October 1945. Jack C. Norris, M.C., U.S.N.R., Atlanta 191

INDEX OF AUTHORS

A

- Anderson, William Willis, Atlanta
Recent Advances in the Treatment of Respiratory Diseases in Infants and Children. October 1945 198
- Aven, C. C., Atlanta
Cooperative Effort Is Needed. July 1945 ... 138
Pain in the Chest: Its Significance. November 1945 221

B

- Barnett, J. M., Albany
Why Are You A Citizen of Dougherty County? January 1945 10
- Bartholomew, R. A., Atlanta
Diagnostic and Therapeutic Uses of Pituitary Extracts in Obstetrics. June 1945 110
- Boland, Frank K., Atlanta
Leather-Bottle Stomach. June 1945 107
- Boston, Roy J., Atlanta
Expanded Typhus Control Program in Georgia. November 1945 231
- Brittingham, John W., Augusta
Coronary Heart Disease: Diagnosis and Treatment. November 1945 219
- Byrd, Edwin S., Atlanta
Heart-Vascular Aging. April 1945 74

C

- Cahal, Mac F., Chicago
American Medicine Tomorrow. March 1945 53
- Campbell, J. L., Atlanta
Treatment of Cancer of the Breast. January 1945 1
- Clifton, Ben H., Atlanta
Common Duct Stones. February 1945 30
- Coker, Grady N., Canton
- Cornett, Dennis M., Canton
- Pilcher, James W., Canton
Ruptured Uterine Myoma Simulating Ruptured Tubal Pregnancy with Hemorrhage. May 1945 94
- Cornett, Dennis M., Canton
- Pilcher, James W., Canton
- Coker, Grady N., Canton
Ruptured Uterine Myoma Simulating Ruptured Tubal Pregnancy with Hemorrhage. May 1945 94

D

- Davison, T. C., Atlanta
I Became A Patient. April 1945 72
- Dobes, Wm. L., Atlanta
- Nippert, Philip M., MC-V (S) USNR
Clinical Aspects and Treatment of Cutaneous Cancer. February 1945 25

E

- Ensign, Paul R., Atlanta
Two Common Infant Feeding Problems. February 1945 40

F

- Fincher, Edgar F., Atlanta
Neurosurgical Aspects of Lumbar and Sciatic Pain. August 1945 150

G

- Goldsmith, Wm. S., Stone Mountain
William Simpson Elkin—1858-1944. May 1945 95

H

- Hailey, Hugh, Atlanta
Relapsing Syphilis After Inadequate Penicillin Therapy. June 1945 116
- Harrold, Thomas, Macon
The Choice and Proper Use of Intravenous Fluids. March 1945 47
- Heyman, Albert, Atlanta
Biologic False Positive Serologic Tests for Syphilis. August 1945 165
- Holmes, Champ H., Atlanta
Clinical Pulmonary Tuberculosis. January 1945 14

K

- Kelly G. Lombard, Augusta
University of Georgia School of Medicine Plans Large Medical Center. August 1945 159

L

- Little, Arthur D., Thomasville
- McCutchen, George T., M.C., Army of the United States
Multiple Arterial Thromboses Involving the Major Vessels of the Lower Extremities and the Right Arm. February 1945 ... 34
- Lunsford, Guy G., Atlanta
Serum Globulin for Measles Immunization. June 1945 123

M

- Martin, William O., Jr., Atlanta
Glaucoma: Its Diagnosis and Management. July 1945 135
- Massee, Joseph C., Atlanta
Treatment of Morphine Addiction. August 1945 154
- McCutchen, George T., M.C., Army of the United States
- Little, Arthur D., Thomasville
Multiple Arterial Thromboses Involving the Major Vessels of the Lower Extremities and the Right Arm. February 1945 34
- McLoughlin, Christopher J., Atlanta
Physical Therapy at Home for Peripheral Arterial Disease. May 1945 91
- Murphy, W. J., Atlanta
The Georgia Cancer Control Program. August 1945 160

N

- Nippert, Philip H., MC-V (S) USNR
- Dobes, Wm. L., Atlanta
Clinical Aspects and Treatment of Cutaneous Cancer. February 1945 25
- Norris, Jack C., M.C., USNR, Atlanta
How Good Is Navy Medical Care In World War II? October 1945 191

P

- Parks, Harry, M.C., A.U.S., Fort Benning

The Use of Antistreptolysin Titer in the Differential Diagnosis of Rheumatic Fever and Allied Conditions. January 1945	5
Petrie, L. M., Atlanta	
Food-Borne Epidemics. April 1945	82
Pilcher, James W., Canton	
Cornett, Dennis M., Canton	
Coker, Grady N., Canton	
Ruptured Uterine Myoma Simulating Ruptured Tubal Pregnancy with Hemorrhage. May 1945	94
R	
Rappleye, Willard C., New York City	
The Supply of Physicians. September 1945	180
Richardson, Jeff L., Atlanta	
Angina Pectoris. October 1945	195
Rinker, J. Robert, Augusta	
Fused Kidney, Having Supernumerary Ureter with Extravesical Orifice; Treated by Heminephrectomy of the Left Half. November 1945	225
Risteen, W. A., Augusta	
Relief From Pain. July 1945	132
Roberts, C. W., Atlanta	
Concerning Georgia's Medical Needs: A Few Facts, Fallacies and Figures. December 1945	239
Rushin, Chas. E., Atlanta	
Combined Surgical and Injection Treatment of Varicose Veins. April 1945	67
S	
Sauls, H. Cliff, Atlanta	
Smith, Carter, M.C., Army of the United States	
Sarcoidosis. May 1945	87
Schenck, H. C., Atlanta	
Tuberculosis: Whose The Burden? June 1945	113
Sinkoe, Samuel J., Atlanta	
Multiple and Solitary Renal Cysts. September 1945	171
Smith, Carter, M.C., Army of the United States	
Sauls, H. Cliff, Atlanta	
Sarcoidosis. May 1945	87
T	
Thompson, Cleveland, Millen	
The Evolution of Medicine. July 1945	127
1945 Christmas Gift: The United Nations Organization. December 1945	249
Current Medical Legislation. May 1945	97
Dog Days. September 1945	179
No State Convention This Year. March 1945	57
Organized Medicine's Plan. February 1945	37
"Perhaps the Word 'Reciprocity' Will Do." July 1945	137
The Challenge of the Field Army of the American Cancer Society. April 1945	77
"Twixt Us Doctors. January 1945	13
William A. Mulherin, M.D. June 1945	117
Turner, John W., Atlanta	
The Surgery of Peptic Ulcer. December 1945	243

W

Walton, John M., Atlanta	
The Georgia Rapid Treatment Centers for Venereal Disease. January 1945	16
Watson, Edwin R., Atlanta and Macon	
Early Congenital Syphilis. October 1945	200
Georgia's "GI" Babies. March 1945	64
Webb, E. L., Atlanta	
False Positive Reactions in the Serodiagnostic Tests for Syphilis. September 1945	184
Whitley, L. L., Athens	
Acacia Treatment of Nephrotic Edema. March 1945	51
Wolff, Bernard P., Atlanta	
Chronic Anxiety. December 1945	250
Y	
Yampolsky, Joseph, Atlanta	
Problems in the Treatment of Rheumatic Heart Disease. November 1945	213

NEWS ITEMS

The Bibb County Medical Society meeting was held at Ridley Hall, Macon, October 16. Dr. A. M. Phillips had charge of the program.

The Georgia Medical Society held its regular meeting at the society's hall, 612 Drayton Street, Savannah, November 13. Paper: "Intravenous Sodium Pentothal Anesthesia", Captain Herbert E. Fitch, Station Hospital, Hunter Field. Mr. Carl Fleetwood, attorney, discussed the Wagner-Murray bill.

Dr. E. A. Roper, Jasper, has returned after serving two years in the Army Medical Corps aboard hospital ships that carried him to North Africa, Italy, England, France and other European countries. He has resumed the practice of medicine at Jasper.

Dr. I. B. Cantor, Atlanta, has returned after taking a two weeks' post-graduate course in surgery at the Cook County Hospital, Chicago.

Dr. A. O. Linch, Atlanta, recently discharged from the U. S. Army, after more than three years of service with the Emory Unit, has re-opened his office for the practice of medicine, 157 Forrest Avenue, N. E., Atlanta.

Members of the Ware County Medical Society were entertained at dinner at the Ware Hotel, Waycross, October 4, by Drs. T. E. Oden, L. M. Hawkins and G. T. Henry, of Blackshear. Dr. L. W. Pierce gave an interesting talk on his experiences in Persia while serving in the U. S. Army. Dr. B. R. Bussell, Dr. G. E. Atwood, Dr. W. D. Mixson, Dr. W. F. Reavis, Dr. B. H. Minchew, Dr. W. P. Stoner, Dr. L. W. Pierce, Dr. W. J. Schneider, Dr. R. R. McCollum, Dr. W. M. Flanagan, and Dr. M. M. Harris attended the meeting.

Dr. William B. Armstrong, Atlanta, announces the re-opening of his office, 806 Doctors Building, Atlanta. Practice limited to ear, nose, throat, and endoscopy.

The Crawford W. Long Memorial Hospital, Atlanta, staff dinner meeting was held in the hospital dining room, November 8. After the business meeting Dr. Joseph C. Massee, Atlanta, discussed the "Treatment of Hypertension." Discussion led by Dr. L. Minor Blackford, Atlanta.

Dr. B. Russell Burke, Atlanta, having returned from active service with the United States Army Medical Corps, announces the re-opening of his office, 705 Doctors Building, Atlanta. Practice limited to diseases of the ear, nose and throat, including bronchoscopy and laryngoscopy.

Dr. Ann McHenry Hopkins, Savannah, announces the opening of her office, 22 East Jones Street, Savannah, for the practice of medicine. For the past seven years she has practiced medicine in Boston. Dr. Hopkins will be part-time resident physician at Telfair Hospital.

According to the *Atlanta Constitution* "Atlantans will receive with pleasure but no surprise, the news that Col. Daniel C. Elkin has been awarded the Legion of Merit award 'for exceptional meritorious conduct in the performance of outstanding service from November, 1942, to July, 1945.'"

"Dr. Elkin, who occupies the chair of surgery at Emory Medical School, is one of Atlanta's best-known physicians. He has attracted national attention in the past by performing a number of radical operations on hearts in which wounds have been made by accidents, gunshot or knife. His new honor is the natural result of the exercise of his usual diligence and ability."

Dr. C. H. Allen, Bremen, was recently appointed as the new Central of Georgia Railway surgeon. He succeeds the late Dr. Eugene Sanford, Buchanan, who died July 20.

Dr. Lawrence P. Matthews, Atlanta, announces the removal of his offices to 1232 South Oxford Road, N. E., Atlanta. Practice limited to obstetrics and gynecology.

Dr. Robert E. Peck, Atlanta, announces the opening of his offices, 722 Doctors Building, Atlanta. Practice limited to neurology and psychiatry. Hours by appointment.

Dr. J. A. Leaphart, Jesup, is the new president of the Eighth District Medical Society. Serving with him are: Dr. W. W. Turner, Nashville, vice-president; and Dr. G. T. Crozier, Valdosta, secretary.

Dr. Nelson Augustus Bryan, Toccoa, has resigned as physician of the LeTourneau Clinic, Toccoa. He has returned to Shanghai and Hwanghsein, Shantung province, China, as a medical missionary of the Southern Baptist Mission Board.

Dr. Tully T. Blalock, Atlanta, recently was discharged from the Medical Corps of the U. S. Navy, after more than two years' service at the Atlanta Naval Air Station. After a year of post-graduate work in Boston he will resume the practice of internal medicine at Atlanta.

Dr. E. C. Demmond, Savannah, was recently named chief of staff of Telfair Hospital. He succeeds Dr. Jabez Jones, Savannah, who had held the post since 1912. Dr. Jones resigned at a recent board meeting, but will remain with the hospital as chief of staff emeritus. The board expressed appreciation to Dr. Jones for his many years of "inspirational service."

Dr. William J. Pendegrast, Atlanta, announces the

opening of offices, suite 715 Doctors Building, Atlanta, for the practice of surgery. He is associated with Dr. Wm. Perrin Nicolson and Dr. Charles S. Ward.

Dr. Charles N. Wasden, Macon, formerly chief of the surgical service of the 15th Evacuation Hospital serving in Africa, Sicily and Italy, announces the opening of his office, 1114 Bankers Insurance Building, Macon. Practice limited to surgery.

The Richmond County Medical Society meeting was held at the University Hospital, Augusta, October 18. Program: "Newer Ideas Concerning Congestive Heart Failure," Dr. Eugene Stead, physician-in-chief of Grady Hospital, Atlanta, and dean of Emory University School of Medicine, Atlanta.

Dr. Philip R. Stewart, Monroe, recently discharged from the U. S. Army, after more than three years' service, most of which time was spent on the Mediterranean Sea on the hospital ship *Shamrock*, off North Africa and France, has re-opened his offices in the Eulalia Building, Monroe, for the practice of medicine.

Dr. J. Dorman Turner, Nashville, recently discharged from the Army Medical Corps, will be associated with his brother, Dr. W. W. Turner, in the practice of medicine and surgery, with offices at the Askew Memorial Hospital, Nashville.

Dr. James Wright Pilcher, Canton, has moved to Wrightsville and will be associated with Dr. Herschel B. Bray in the practice of medicine and surgery.

Dr. James I. Weinberg, Atlanta, announces the re-opening of his offices temporarily at 762 Cypress Street, N.E., Atlanta. Practice limited to internal medicine. Hours by appointment.

Dr. F. Bert Brown, Savannah, recently discharged from the service, after more than three years' service as chief of orthopedic surgery at Camp Rucker, Ala., and Thayer General Hospital, Nashville, Tenn., announces the re-opening of offices at Savannah.

The Post-Graduate Medical Assembly given under the auspices of the Fulton County Medical Society, Atlanta, Nov. 1-2, 1945, included: Program November 1: "Clinico-Pathological Conference," Drs. Paullin, Madden, Parker and Sheldon; "Gastro-Intestinal Malignancies," Dr. Calvin Stewart; "Dermatological Clinic. The Common Skin Diseases," Lantern slides, Dr. Wm. L. Dobes; "Protein Nutrition," Dr. Sidney Madden; "Treatment of Chronic Congestive Failure," Dr. Jos. C. Masee; "A Pediatric Problem," Dr. Don F. Cathcart; "Recent Experiences in the Treatment of Brain Abscesses," Drs. Fincher and Swanson; "Colon Surgery," Dr. Deryl Hart, Duke University, Durham, N. C.; "Newer Treatment of Syphilis," Dr. Albert Heyman; "Treatment of Bronchiectasis," Dr. Osler Abbott; "Surgical Experiences in North Africa and Italy," Dr. J. D. Martin, Jr.; Dinner at the Academy of Medicine; Papers of the evening: "Appendicitis," Dr. Deryl Hart, Duke University; "Some Problems in the Management of Heart Disease," Dr. Sam Proger, Tufts Medical School, Boston, Mass. Program November 2: "Magnetic Removal of Foreign Bodies from the Food and Air Passages," Dr. Murdock

Equen; "Medical and Surgical Treatment of the Peptic Ulcer," Drs. Van Buren and Grove; "Treatment of Trichomonas Vaginalis," Dr. Fred Minnich; "Presentation of Cases," Dr. E. A. Stead, Jr.; "Diagnosis and Management of Injuries of Lower Urinary Tract," Drs. Floyd, Pittman, Florence and Weens; "Chemotherapy in Medical and Surgical Infections. Round table discussion." Drs. Beeson, Akin and Childs; "Medical Clinic. Fever of Undetermined Origin," Dr. Sam Proger; "Food Allergy," Dr. Hal M. Davison; "Thiouracil and the Treatment of Hyperthyroidism," Dr. Emmett Brannon and Dr. Ben H. Clifton.

Dr. Joseph Pacifici, Savannah, has been released from active duty by the U. S. Army, after more than three years' service, and announces the re-opening of his offices for the practice of medicine, 415 Abercorn Street, Savannah.

Dr. Warren C. Baxley, Blakely, recently discharged from the armed services, after having served for more than four years, two of which were abroad, has re-opened his offices for the practice of medicine and surgery at Blakely.

The Milledgeville State Hospital medical and dental staffs are being increased as rapidly as trained personnel can be obtained, Director A. J. Hartley of the State Department of Public Welfare, declared recently. He hopes eventually to increase the medical staff from the present 21 physicians to at least 50, and the dental staff from 3 to 6. Dr. B. B. Bagby, Jr., of Richmond, Va., has come to the mental hospital to head the tuberculosis program, and Dr. Roy Mack, of Atlanta, has been added to the dental staff. Director Hartley also announced the appointment of Dr. Fred G. Hodgson, dean of orthopedics at the Emory University School of Medicine, Atlanta, as orthopedic consultant of the Crippled Children's Division of the State Welfare Department.

Dr. T. A. Futch, Jr., Thomasville, recently discharged from the U. S. Army, after more than two years of service in India and Burma, has opened his offices for the practice of medicine at Thomasville.

Dr. Patricia Dodd, Savannah, has been named resident physician at the Georgia Infirmary, Savannah. Dr. Dodd did under-graduate work and received her doctor's degree at the University of Maryland.

Dr. Jacob Rubin, Savannah, has been released from the U. S. Army. He was with the Seventh Army in the landing at Oran, North Africa, then went to Italy and into Southern France with the invasion there in September, 1944. He has opened offices for the practice of medicine at Savannah.

Dr. David L. Salmon, of Madisonville, Ky., announces the opening of his office, Buckhead Theatre Building, Atlanta. Practice limited to eye, ear, nose and throat diseases.

Dr. Needham B. Bateman, Atlanta, has recently been discharged after over five years of active duty, two years of which were spent in the European Theatre

of War, and plans to open his office, the early part of the coming year, in the Candler Building, Atlanta, for the practice of surgery.

Dr. Hugh Hailey, Atlanta, recently discharged from the U. S. Navy, after more than four years' service both in the European and Pacific Theaters of War, has opened his offices for the practice of dermatology, 911 Medical Arts Building, Atlanta.

OBITUARY

Dr. Robert Mayhue Ware, aged 62, beloved physician and surgeon of Fitzgerald, died suddenly following a heart attack, Oct. 23, 1945. He graduated from the University of Georgia School of Medicine, Augusta, in 1902, and began the practice of his profession at Wright, later moving to Fitzgerald. Dr. Ware was a member and president of the Ben Hill County Medical Society, the Medical Association of Georgia, the American Medical Association, and the Central Methodist Church, in which he had served as an official for many years.

He was a man of outstanding ability, a man who placed his profession ahead of his pleasures, a consistent Christian, liberal in all ways, and a man who loved his family and friends devotedly.

His first wife, Mrs. Greta Garbutt Ware, died in 1930. He is survived by his second wife, Mrs. Sarah Pollard Ware, and the following children: Virginia Ware, New York City; Susan Ware, Jacksonville, Fla.; Pharmacy Mate 2/c Martha Ware, Charleston, S. C.; Ensign Lane Ware, Washington, D. C.; Bill Ware, Macon; Mary Helen Ware, Sarah Bob Ware, and Bob Ware, all of Fitzgerald; two brothers, Dr. D. B. Ware, Fitzgerald; and N. E. Ware, Cordele; three grandchildren, Greta and Bob Ware, Fitzgerald, and Lane Ware, Macon.

Funeral services were held from the Central Methodist Church, Fitzgerald, with Rev. Wade E. Scott, pastor, officiating, assisted by Rev. E. S. Winn, of the Presbyterian Church, Rev. Carey T. Vincent, pastor of the First Baptist Church, and Rev. J. O. J. Taylor, Macon, a former pastor. Burial was in Evergreen Cemetery.

ANY PHYSICIAN MAY EXHIBIT "WHEN BOBBY GOES TO SCHOOL" TO THE PUBLIC

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the-public film, "When Bobby Goes to School," may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

GEORGIA NURSING NEWS

(Continued from page 253)

will continue for another year, at least, but without funds. The name will be revised. The words "for war service" will be dropped and the program will continue as a state nursing council. The original plan of organization relationship will exist; that is, the executive board of the Georgia State Nurses' Association will function as the executive committee of the State Nursing Council.

2. Limited funds were allocated by the Georgia Nurses' Association for the Counseling and Placement Service. If the program is to be established, additional funds will be needed.

3. Institutes are being planned by the Georgia League of Nursing Education and Georgia Industrial Nurses' Association for 1946, on special programs.

4. Special resolutions were adopted at a special memorial service upon the death of two charter members of the Georgia State Nurses' Association — Mrs. Eva S. Tupman, Atlanta; and Miss Rebecca Greene, Savannah — and 13 other members during the year; two of whom were nurses with the military services and died on foreign soil.

A special resolution was also adopted upon the death of Dr. S. V. Sanford, chancellor, University System of Georgia. Dr. Sanford gave great impetus to the advancement of nursing education in Georgia. This resolution will be published in the January 1946 issue of this journal.

5. All six state nursing groups elected or re-elected some few new officers.

Mrs. Olive L. Barbin, director of nursing service, Richmond County Health Department, Augusta, was elected president of the Georgia State Nurses' Association. Mrs. Barbin has served for several years as a member of the executive board and will, as president, promote nursing interests throughout Georgia, and greatly influence the health and welfare of the State.

FIND RIGID CONTROL OF SALT INTAKE LOWERS HIGH BLOOD PRESSURE

Rigid control of salt intake has been found helpful in lowering high blood pressure, according to a report in the October 20 issue of the *Journal of the American Medical Association*.

Six investigators — Arthur Grollman, M.D., T. R. Harrison, M.D., M. F. Mason, Ph.D., James Baxter, M.D., Joseph Crampton, M.D., and Francis Reichsman, M.D., of Dallas, Texas — severely restricted the salt in the diet of six patients. The blood pressure in two was reduced to essentially normal levels, while in three others there was a moderate reduction.

The authors, who are from the Department of Experimental Medicine of the Southwestern Medical College and the Medical Service of the Parkland Hospital, state that "the results thus far obtained would appear to indicate that in certain patients this form of therapy is decidedly beneficial."

Although experiments in controlling salt in the diet have been made at different times in France, Germany and the United States none have so far proved successful. The authors believe that they failed because of the employment of moderate, rather than drastic, restriction of salt in the diet. Moderate restriction, they state, usually fails to influence appreciably the blood pressure.

As yet, the effect of rigid salt control has not been studied during hot weather and the investigators believe that harmful effect may occur when sweating is excessive.

In conclusion the report says that "in view of the relative ease with which this method can be applied it seems to offer, for certain patients, the most practical and effective therapeutic measure now available."

NOTED DOCTOR TELLS HOW POST- MORTEM SHOULD BE MADE ON HIS OWN BODY

"Because he believed that the public did not 'sufficiently realize the importance of postmortem examinations,' the late Lord Dawson gave specific instructions in his will as to how such an examination should be made on his own body, according to the October 13 issue of *The Journal of the American Medical Association*.

Lord Dawson was physician to the London Hospital and served twice as president of the British Medical Association. He died last March 7 at the age of 81. Here, in his own words, he gives his views on the importance of a post-mortem examination to medical science:

"I do this because I think the public do not sufficiently realize the importance of postmortem examinations being made and the advantages to knowledge and therefore to future generations which will accrue. We do not hesitate to have operations performed on our bodies when we are alive and circumstances require it. Why then should we mind operations (which are done with the same care, the same gentleness, and, I may add, the same reverence) being done to our bodies when we are dead? Surely this is rightful service which the dead should give to the living. The benefit of such service to the living is very great."

INCIDENCE OF SYPHILIS

According to *The Journal of Disease Information*, in a recent release concerning the incidence of syphilis, the following facts were noted:

An analysis based on information concerning occu-

pation and marital status for a random sample of men examined for Selective Service showed that the prevalence of syphilis varies widely among different occupational groups. It also showed that in any occupation group the prevalence of syphilis is substantially higher among single white men than among married white men but the differences between single and married groups among nonwhites was small.

The analysis was based on the results of serologic tests for syphilis performed on 531,236 Selective Service registrants who constituted a 20 per cent sample of the men examined from January 1, through May 31, 1945. Blood tests were tabulated according to age, race, marital status, and 11 broad occupational groups.

The prevalence of syphilis among single white men ranged from one or two per thousand for 17-year-old men in each occupational group to approximately 30 per thousand for the 37-year-old men in the professional group, 50 per thousand for proprietors, 45 per thousand for clerical, 45 per thousand for salesmen, 80 per thousand for craftsmen, 80 per thousand for operatives, 35 per thousand for service workers, and 90 per thousand for laborers.

The prevalence rates for married white men were 25 to 50 per cent lower than for single white men in corresponding occupational groups. In general among the white men, the differences between the syphilis rates of single and married men were much greater than were the differences between occupational groups, and these differences were least in those occupational groups having the highest syphilis rates.

Among Negro men a tendency for higher prevalence rates among the less skilled occupational groups was apparent but not statistically significant, and no statistically significant difference between married or single groups could be demonstrated.

The rates for the several occupational groups of Negro men ranged from about 20 per 1,000 among 17-year-old single Negroes in the more highly skilled occupational groups to more than 300 per 1,000 among 37-year-old Negro men in unskilled groups.

Prevalence rates for students were lower than for other groups on the whole. Rates for men other than married or single were compared, as a group, and the comparison showed that white men in this group had significantly higher rates than either the single or the married men in corresponding age groups.

The investigators conclude that undoubtedly there is a correlation between occupation and the prevalence of syphilis, but that this does not imply a casual relationship; except among the highly trained and the completely unskilled; cultural patterns probably have far greater weight, which may in part explain the differences that are constantly observed in the prevalence rates among different races.

The investigators suggest further and more detailed studies to augment this analysis since the sample is fairly small, the population is limited to men subject to draft, and the occupational groups are broad and in several respects unsatisfactory for study in this particular field.

NEW MEDICAL JOURNAL

A new bi-monthly medical journal, *Geriatrics*, devoted to research and clinical reports on the processes and the diseases of the aged and aging, will appear in January, 1946, Modern Medicine Publications announces.

For sometime the need for a journal of this type has been increasingly apparent. The market among patients of fifty and over is growing steadily. By 1975 it is estimated that 40 per cent of our population will be in that group. Whatever information serves to increase the life span of the individual, whether a matter of diagnosis and treatment, surgical intervention or proper nutrition is very much in accord with the thinking of the times. The editorial direction of *Geriatrics* will stress the investigations and advances made in the study of geriatrics and report on the clinical applications of new developments.

The editor is Dr. A. E. Hedback, who has been the editor of *Modern Medicine* since its inception. The editorial board serving with Dr. Hedback consists of a group of distinguished medical authors and editors, specialists in the field of geriatrics.

WORLD WAR II CASUALTIES

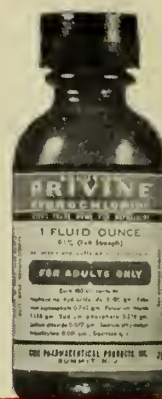
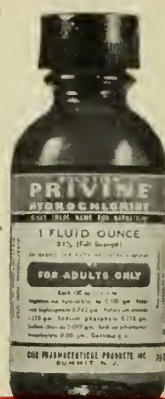
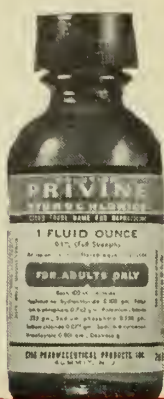
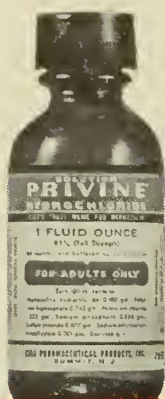
Sixty-three per cent of the wounds received in World War II were those of the upper and lower extremities, with the lower extremities the heaviest proportion, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently before the Milwaukee Association of Commerce.

"There were 207,754 men of the United States Army killed in action and 571,490 wounded," General Kirk stated. "Of those wounded, 363,322 returned to duty after hospitalization, and 25,145 died. These figures indicate that the rate of those wounded who died was nearly twice as great in World War I."

Of the 15,000 amputees of World War II, 14,000 needed artificial limbs, 7,000 of whom still remain in general hospitals. The balance either returned to civilian life or remained on duty as instructors for other amputees, the General continued. There have been two quadruple amputations and nine triple amputations recorded in World War II. Of the 14,000 needing prostheses, 95 per cent have lost one arm or leg, and 5 per cent have suffered two major amputations.

Outlining the Army's job in medical care and rehabilitation of the wounded, General Kirk also stressed the part of the American public in helping the returned veteran, and concluded, "Too many men in the last war became social derelicts because too little responsibility was assumed by business and industry in placement of the individual in a job commensurate with disabilities. Those men have won the war, now let us help them win the peace."

WANTED PHYSICIANS—There are many vacancies with the Veterans' Administration for full time, part time and fee basis physicians over the state. Any one interested, please communicate with the Manager, Veterans' Administration, 5998 Peachtree Road, Atlanta.



PRIVINE^{*}

HYDROCHLORIDE

ACCEPTED

PRIVINE Hydrochloride (Naphazoline) has been accepted for inclusion in New and Non-Official Remedies of the Council on Pharmacy and Chemistry of the American Medical Association. The following dosages are recommended: 0.1% for adults — 0.05% for adults and children.

^{*}Trade Mark Reg. U. S. Pat. Off.

CIBA PHARMACEUTICAL PRODUCTS, INC.

SUMMIT, NEW JERSEY

IN CANADA, CIBA COMPANY LIMITED, MONTREAL

